Maternal and Child Health Services
Title V Block Grant

State Narrative for Arkansas

Application for 2011
Annual Report for 2009

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

All assurances and certifications are kept on file in the Center for Health Advancement, located in the Arkansas Department of Health in Little Rock.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Among the avenues for public input into the activities supported by the Title V Maternal and Child Health Block Grant is a survey of the family planning patients who utilize the Arkansas Department of Healths clinics. This survey asks family planning patients about their level of satisfaction with the services they have recieved, the wait times they experienced, how accessable the services were, as well as their impression of the staff who served them. This information is used in evaluating the individual clinics as well as identifying problems that are systemic to the program. In turn this helps identify problem areas that are concidered when planning and development of new initiatives are undertaken by the MCH program. Other avenues for public imput include, but are not limited to the parent/advisory group for CSHCN and the survey CSHCN conducts with parents and families.

As prescibed by the Federal Government as part of the application process, the first of two Public Hearings for the 2011 Title V Maternal and Child Health Block Grant application took place on July 1, 2010. The hearing took place at the Arkansas Department of Health Auditorium in Little Rock, Arkansas starting at 2:00 pm. A notice was placed in the Arkansas Democrat Gazette-Northwest, the Arkansas Democrat Gazette-Little Rock and Hola Arkansas in both English and Spanish, for seven consecutive days, one month previous to the hearing. Notices were also placed on the Arkansas Department of Health website and the Arkansas State Calendar of Public Meetings website during the 30 day period preceding the public hearing. Copies of the draft application and report were made available for review at the hearing. Eleven people attended the hearing, and there were no questions or comments.

The second MCH Block Grant Public Hearing took place on August 3rd, 2010, at which time copies of this document were shared and open for discussion. The hearing took place at the Arkansas Department of Health Auditorium in Little Rock, Arkansas starting at 2:00 pm. A notice was placed in the Arkansas Democrat Gazette-Northwest, the Arkansas Democrat Gazette-Little Rock and Hola Arkansas in both English and Spanish, for seven consecutive days, one month previous to the hearing. Notices were also placed on the Arkansas Department of Health website and the Arkansas State Calendar of Public Meetings website during the 30 day period preceding the public hearing. Although no public comments were made during the public hearing, we will

continue to welcome comments from the parent/advisory group for CSHCN, as well as other groups with input regarding the served population. after the

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The 2011-2015 Needs Assessment provides a thorough portrayal of the health status of pregnant women, infants, children, youth, and children with special health care needs in Arkansas. Following a comprehensive analysis of many pieces of data from a multitude of sources, the MCH program has identified relevant trends in key health measures for all these sub-populations. State and community capacity to address needs has also been delineated. As a result of data analysis and an organized effort to solicit input from numerous partners and stakeholders, several priority areas have been identified, although many other issues will continue to be pursued with intense effort as well. Priorities for 2011-2015 are to:

-Reduce births to older teens
-Reduce smoking among women of childbearing age
-Improve trauma care for children
-Improve oral health in children and women
-Reduce obesity and overweight among school-aged children
-Improve communication between the Title V CSHCN program and the CSHCN population
-Improve training and program development for the Title V CSHCN workforce

Since the last 5-year Needs Assessment, a number of important trends have been studied with respect to health status of the various sub-populations. Births to 18-19 year olds have not increased, but have remained continually very high in Arkansas. The state has the highest birth rate in the nation to this age group according to a recent Guttmacher analysis. As for smoking among women of childbearing age, Arkansas ranked eighth-highest in smoking-attributable mortality among females in a 2009 CDC report. Trend analysis also demonstrated that rates of smoking-related mortality among Arkansas women were increasing during the past decade. Child deaths due to injury have also persistently plagued Arkansas for many years, although provisional data for 2008 show evidence of decline. The state has never before had any semblance of a statewide trauma system. The absence of such a system has been blamed for a significant portion of the state's excess injury mortality. Oral health is a problem for many Arkansans, but especially for children and women. While strides have been made over the last ten years in the proportion of Arkansans whose public water supply is fluoridated, much work remains. The same can be said for obesity and overweight prevention. The state has one of the highest childhood obesity rates in the country. Rates of overweight/obese among school-aged children in Arkansas have changed little over the last five years, but institution of much stricter controls on school nutrition and vending practices may have at least helped to stabilize what before was a rapidly increasing trend. To prevent major morbidities and premature mortality in later life, continued emphasis on prevention of childhood obesity is imperative. Technology limitations within the CSHCN system must be addressed to enable families and professionals statewide the ability to research and connect with the services already in place to serve CSHCN. The same technological limitations impact the training needs of the CSHCN workforce.

Capacity to address the chosen priorities is also a vital consideration. Since the last 5-year Needs Assessment, changes have definitely occurred with respect to the teen births priority. Funding for both the Unwed Births and Abstinence Education programs has lapsed, taking some MCH administrative capacity with them. However, new opportunities exist with recently announced federal teen pregnancy prevention initiatives. Other newly acquired capacity includes nine school wellness centers to be established in the 2010-11 school year. More could also be

done through existing ADH family planning clinics and around the Medicaid FP Waiver. Capacity related to smoking reduction in women has not changed appreciably, but again more could be done through ADH clinics. A major change in capacity related to childhood injury is the recent work to begin development of a statewide trauma system. A new section has been born within the Injury Prevention and Control Branch, multi-agency work groups have been established and a state trauma registry is being created. These efforts will undoubtedly pay off in reduced injury mortality over the next several years. Capacity for improved oral health is growing steadily as a result of partnerships between ADH and the Delta Dental Foundation and private entities such as Arkansas Children's Hospital (including the Natural Wonders movement). Momentum continues to grow toward the goal of full fluoridation of all public water systems. Capacity to combat childhood obesity also continues to grow steadily through activities of the Child Health Advisory Committee, Coordinated School Health, the Arkansas Coalition for Obesity Prevention and grants to communities from private funders such as Robert Wood Johnson. CSHCN capacity for improvement in communication and access to quality information and services on special health care needs will involve the state of Arkansas' contractors, Northrop Grumman and Information Network of Arkansas (INA). Dedication of staff time to the development of these resources will be required, as well. In addition, collaboration with DHS Office of Human Resources Organizational Development and Training will be required to develop the online employee resources required.

III. State Overview

A. Overview

1. State Characteristics

As of 2008, Arkansas's population stood at 2.86 million people spread across 75 counties. Among states, Arkansas has high proportions of rural, low income and minority citizens. A very broad range of health measures in this state rank unfavorably compared to other states. These include many of the data trends captured in the MCH Block Grant performance measures. Arkansas's five health regions are diverse in geography and demography. The Central Region around Little Rock is relatively urban and well supplied with available health services for women and children. However, even in these counties low-income families experience barriers in access to care. All other regions are rural and poor and many are medically underserved as defined by HRSA programs. Counties along the eastern border of Arkansas, the Mississippi Delta, are especially rural and poor and have high concentrations of minority populations, especially African American. Counties along the western border are mountainous and rural. They have fewer minorities, but are high impact for immigrant Hispanic families from Central and South America. A group of Marshallese families live in the far northwestern counties and experience outbreaks of infectious diseases including STIs, TB and Hansen's Disease. Counties along the southern border of the state are also rural and poor, depending on farming and timber as their predominant source of income.

2. The broader health delivery system

The city of Little Rock, the state's largest, is situated approximately in the middle of the state, and is the site for five large hospitals, the University of Arkansas for Medical Sciences (UAMS - the medical school), the Arkansas Department of Health (ADH), the Arkansas Department of Human Services (DHS), and other state agencies relating to the health of women and children. Cities of moderate size are located in the corners of the state, including Fayetteville and Fort Smith in the northwest, Jonesboro in the northeast, Hot Springs in the midwest, Texarkana in the southwest, El Dorado in the mid south, and Pine Bluff in the Delta Region of the Mississippi River. These cities provide the population base for sizable medical communities and are the locations of Area Health Education Centers (AHECs). Over the state as a whole, the number of physician practices is barely adequate to provide the necessary medical services, but in certain underserved areas, physician and other health provider shortages are common. UAMS, based in Little Rock, provides a centralized point of referral for all medically complicated patients, and also provides medical and health education for the entire state. Except for the communities of West Memphis and perhaps Helena on the eastern border of the state who depend on the city of Memphis in Tennessee, all state communities relate to UAMS and Little Rock hospitals as the major source of highly specialized medical care. The AHECs provide Family Medicine residency training in communities around the state, and have been of great assistance in improving the distribution of primary care physicians to the corners of the state. By far the most numerous specialty in Arkansas, family physicians provide most of the state's medical care. Specialists in obstetrics, pediatrics, internal medicine, surgery and others have practices in the more urban communities. While Arkansas is geographically of modest size compared to some other states, the distances from cities such as Fayetteville and Texarkana to Little Rock require two and one-half to four hours of travel time. For families with few resources, these distances represent significant barriers in access to highly specialized care.

A major advance in both access to care and provider education occurred in 2009 with the opening of UAMS Northwest, a 325,000 square foot facility located in Fayetteville. The site is expected to educate 250-300 students when fully operational, including medical, pharmacy, nursing, and allied health professions. Faculty, medical students, and residents have already begun training at the site. Arkansas Children's Hospital has also established a satellite facility in northwest Arkansas at Lowell, which is staffed by the UAMS Department of Pediatrics.

3. The system of state agencies providing support to the health system for women and children.

Following separation from the Arkansas Department of Human Services in 2007 after a two-year "marriage," the Arkansas Department of Health (ADH) is again an independent, cabinet-level agency. A table of organization for the ADH is attached under III.C., Organizational Structure.

Dr. Paul Halverson is the Director of the ADH, and serves as Secretary to the State Board of Health. Dr. Joseph Thompson serves as the chief medical adviser to the Governor (referred to as the state's "Surgeon General"). Both are cabinet positions and are active in the deliberations of the Arkansas Board of Health, though the Surgeon General does not have a vote, and the Director may not serve as chair. ADH structure includes the Executive Staff (providing overall leadership), and five Centers, including Local Public Health, Health Advancement, Health Protection, Health Practice, and the State Laboratory. MCH services are coordinated through the Family Health Branch in the Center for Health Advancement.

Since 2007, both the structure and the focus of the "new" ADH have become well established. As State Health Officer, Dr. Paul Halverson conducted a strategic planning process in 2008. Guided by a nationally experienced facilitator, the ADH Executive Team and Senior Staff developed a Strategic Map for the years 2008-2012. A copy of that map is attached. The overall goal of the ADH is to improve health and reduce disparities. Under that goal there are five Priority Areas:

1) Strengthen Core Services --(Family Planning, Prenatal Care, Immunizations, WIC, Home Health, etc.) by quality assessment, recommendations for improvement, implementation of those recommendations and re-evaluation.
2) Develop more Effective Population-Based Approaches --(injury prevention and control, reduce infant mortality, increase physical activity, and improve oral health).
3) Communicate Public Health Value and Societal Contribution --(economic development, public awareness, benefits of prevention).
4) Secure Adequate Human and Financial Resources --(workforce needs, workforce training, gaps, funding acquisition).
5) Increase Departmental Effectiveness and Accountability --(strengthen leadership, management systems, IT infrastructure, data utilization, accountability).

Cross-cutting all these areas are emphases on community engagement, partnerships, and policy development. The overall theme is to strengthen and improve traditional public health clinical services; and, at the same time, focus on several specific program developments, engage more in public awareness and policy developments, and retool administrative processes to work more effectively and efficiently.

Since 2008, ADH health services have been prioritized according to the strategic plan. Highest priority services are provided by ADH in all counties. Such services include Immunization, Family Planning, WIC, STI, infectious disease outbreak management, Breast and Cervical Cancer Control, and environmental health. Other high-priority services are provided not in the local clinics, but through the Central Office. These include newborn metabolic and hearing screening, and collaborations with Medicaid to assure enrollment in Medicaid and appointments with primary care physicians. Second priority services include basic preventive services for which availability is necessary in all counties, but for which local health systems may not have sufficient capacity. These include maternity care, maternal and infant home visiting and home health services. The maternal and infant home visiting program provides nursing assessment, teaching and referral for mothers and infants, to bridge the gap between hospital and continuing medical care in the community. This program served over 5800 patients in 2009. The remaining priorities include those preventive services that are optional for counties such as services for patients with diabetes and hypertension.

The Arkansas Department of Human Services (DHS) is a very large state agency which houses a number of programs of importance to maternal and child health. The Division of Medical Services conducts the Medicaid Program, which serves about 400,000 children at any given time. Of these children, about 325,000 are covered on the basis of income eligibility, known in Arkansas as ARKids First (ARKids A and ARKids B, depending on income level). Almost 30,000 women receive pregnancy-related Medicaid coverage each year. DHS is also home to the state Title V Children with Special Health Care Needs (CSHCN) program, which is found in the Division of Developmental Disabilities (DDS). CSHCN services are closely associated with specialty services of the Department of Pediatrics at UAMS. DDS additionally supports the state's early intervention services program (Part C). Another DHS unit, the Division of Children and Family Services, conducts programs to protect children who are abused, neglected, orphaned, or otherwise in need of basic care.

As the only medical school in the state, the role of UAMS in Arkansas's health care system is difficult to overestimate. Development of the College of Public Health within UAMS since 2001 has led to much stronger links between state health-engaged agencies and the university. UAMS is also the sponsoring entity for the Arkansas Center for Health Improvement (ACHI), a collaborative effort designed to promote public health research and translation into practice. UAMS supports ten Area Health Education Centers (AHECs) scattered around the state, which provide direct care and training of family medicine residents. The university's pediatrics and obstetrics/gynecology departments are very strong partners with ADH in the provision of direct care to women and children. These departments also partner with ADH to carry out ongoing public health programs and other initiatives to improve systems of care. A prime example of the latter is the Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS) project, which is described more fully in later sections.

Although not state-supported per se, the role of Arkansas Children's Hospital (ACH) in the health system deserves special mention. ACH is one of the largest children's hospitals in the U.S., attracting patients from around the region and even other countries. ACH provides a large proportion of the pediatric critical care in the state. Apart from direct care provision, the hospital's administration is also committed to involvement in community- and state-level public health concerns such as infant mortality reduction, injury prevention, and school health initiatives.

The 77 general hospitals in the state provide the bulk of in-patient care. The Arkansas Department of Health works closely with these local providers to assure that standards of care are met. Apart from this regulatory relationship, at the systems level ADH also regularly partners with the Arkansas Hospital Association on issues of common interest.

Professional boards of Medicine, Nursing, and other disciplines are examples of other state agencies that provide support to the health system. These disciplines, along with dentistry, pharmacy, chiropractic, and hospital administration, are all represented on the Arkansas Board of Health.

Given the extreme problems of poverty, racial and ethnic inequality, and rurality inherent to Arkansas, the need for collaboration among health system stakeholders becomes evident at every turn. The many partnerships that have been developed in recent years to help promote and provide Title V-related services will be elaborated on in subsequent sections.

An attachment is included in this section.

B. Agency Capacity

Arkansas has a variety of state statutes that guide the provision of services to mothers and children. There is no overall statutory authority for the MCH population, so existing statutes will be discussed within each of the sub-populations.

1. Primary and Preventive Services for Infants and Pregnant Women

Maternity services work to ensure all pregnant women in Arkansas have access to early and continuous prenatal care, thereby reducing the number of preterm and low birth weight infants and lowering infant mortality and maternal morbidity and mortality.

Target Population: Pregnant women in Arkansas, specifically those with no other source of prenatal care.

Description of Services: ADH Maternity clinics provide prenatal services, including risk assessments, laboratory, physical assessments, patient counseling, prenatal education classes, nutrition, social work counseling and referrals for high-risk care. Case management and follow-up ensures patients receive services needed. Medicaid eligibility is determined and, where possible, patients are referred to local physicians for continuance of care. All Local Health Units offer basic pregnancy testing and counseling, and referral to local physicians or to a neighboring Unit giving prenatal care. Working with the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS, ADH anticipates implementing new screening methods for smoking, depression, partner violence and substance abuse. State law requires that all pregnant women be tested for HIV, unless they have been counseled and have refused the test.

All local health units provide pregnancy testing, prenatal counseling, and screening for presumptive Medicaid eligibility. The county health units work with nearby local health units and other care providers to ensure pregnant women have access to early prenatal care. Clients are provided referral information and accessibility to other ADH services, such as WIC and Immunizations. In 54 sites, located in 49 counties, ADH also provides prenatal clinic care that includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, smoking cessation referrals and referrals as indicated for high risk care. ADH clinicians and public health nurses work closely with the University of Arkansas for Medical Sciences' perinatal program, ANGELS. With significant financial support from Medicaid, ANGELS provides evidence-based guidelines for maternal-fetal and neonatal care.

Maternity clinics in local health units may open or close as physician support wanes or waxes locally. However, prior to closure of a maternity clinic, earliness of prenatal care data from the community are always assessed to make sure minimum criteria are being met.

The Lay Midwife Licensor program, with ADH legal support and major input from licensees, oversees regulations pertaining to the practice of lay midwives. Those regulations last received major revisions in the spring of 2007. Program staff provides support, training, and assistance in continuing education to the 30 lay midwives currently licensed. Reporting forms for use by midwives are developed by the program and approved through the Arkansas Board of Health and Arkansas Legislature as required. Forms were last revised in 2008. Among other things, the forms provide information on deliveries provided by the midwives and any complications encountered. This information is then used to help assess training needs and to evaluate midwives applying for re-certification, which is required every two years.

ADH operates a home health program called In-Home Services. Part of the care it provides is called the Maternal and Infant Program (MIP). MIP, if requested by a local health unit and

approved by Family Health Branch medical staff, will make home visits to pregnant women at risk. For example, one at-risk group includes pregnant adolescents who would benefit from home assessment and further follow-up. In addition, MIP visits pregnant women who have medical complications such as pre-eclampsia requiring bed rest, diabetes requiring insulin therapy, or infants requiring special monitors or IV therapy. These visits are ordered by local physicians.

ADH continues to support the Healthy Baby/Happy Birthday Baby Book. Healthy Baby is a program of the Arkansas Department of Health that encourages all pregnant women to receive early and continual prenatal care. The Happy Birthday Baby Book can be requested by phone, internet or prepaid postcard.

Established in 1991, the ADH Resources and Health Information Line is a statewide, confidential, toll free information system that operates Monday-Friday, 8:00am to 4:30pm. It is staffed with employees trained to provide callers with public health and referral resource information. An electronic intranet resource is available to local health units through the ADH Intranet.

2. Primary and Preventive Services for Children

The purpose of the Child and Adolescent Health Program is to promote safe and healthy development of children so that all may achieve their full potential.

Target Population: Birth to age 21 for the State of Arkansas.

Description of Services: Child and Adolescent Health (CAH) currently comprises three major programs at the state level: newborn metabolic (blood spot) screening, newborn hearing screening, and Coordinated School Health. Other smaller programs such as SIDS grief counseling and limited lead poisoning prevention activities are also coordinated through this Section. Injury prevention activities, formerly a strong focus within CAH, were moved to a newly created branch within the Center for Health Protection in 2007. Abstinence education activities previously resident within CAH were suspended as of June 30, 2009 due to discontinuation of state and federal funding. Finally, at the local level, Immunizations and WIC constitute the primary programs available to children.

State statutes provide the legal basis for newborn metabolic and hearing screening. An important change to the newborn (metabolic) screening law occurred in 2005. At that time, the Arkansas Legislature mandated screening for cystic fibrosis and "other tests" as provided for through the Arkansas Board of Health. Prior to this time, each disorder screened for was mandated by a separate act of the Arkansas Legislature. Since the 2005 change in code, new disorders can be added on the authority of the Arkansas Board of Health alone. Thus, in 2007 the Board approved expansion of newborn screening to encompass all 28 metabolic disorders recommended for screening by the American College of Medical Genetics. To cover costs of the expansion, the Board also allowed for a large increase in the fee charged for screening. Expanded screening for all 28 disorders commenced July 1, 2008.

Rules and regulations governing newborn metabolic screening require birthing hospitals and other providers to obtain heel-stick blood specimens from newborns and submit them to the Public Health Laboratory. The program's follow-up system is electronically linked to the laboratory data system, so positive results are automatically transmitted to follow-up nurses. Working under explicit protocols for each disorder screened, the nurses then convey the positive results and needed diagnostic testing to physicians by phone, fax, and regular mail. Follow-up contacts are then made at prescribed intervals to obtain results of confirmatory testing. In addition to this short-term follow-up, long term follow-up for infants diagnosed with a disorder through newborn screening (NBS) is conducted through five years of age. A somewhat unique feature of Arkansas's NBS program is the inclusion of an outreach nurse who provides regular scheduled visits to every birthing hospital in the state to provide training and updates on specimen collection techniques. A matching program developed within the Health Statistics

Branch links birth records with newborn screening forms to determine the proportion of infants screened at each birthing hospital. This information, along with lab-generated hospital-specific data on percent of unsatisfactory specimens, is utilized by the outreach nurse at every visit to a hospital.

For infant hearing screening, the applicable Arkansas Statute (Act 1559 of 1999) mandates that all hospitals delivering over 50 babies a year conduct physiologic hearing screening on newborns and report the results to the ADH. In Arkansas, all current birthing hospitals deliver more than 50 infants per year, providing the potential for almost complete screening coverage. For both metabolic and hearing screening, parents are allowed to refuse screening, but historically very few refuse each year. Results of hearing screens conducted at hospitals are transmitted to program staff, who then follow up to assure that re-screens and/or diagnostic audiological testing are carried out. Program personnel are currently in the midst of preparing to change to an electronic system of follow-up that will be linked to the state's Vital Records (electronic birth records) system. With this new system (to be implemented in 2011), infants not receiving a hearing screen will be easily determined, and results and follow-up information will flow more efficiently in all directions.

Coordinated School Health activities are actually based at the Arkansas Department of Education (ADE). Since 2006, the ADH and the ADE Office of Coordinated School Health have partnered to support establishment of Coordinated School Health initiatives (CSH) in Arkansas. In 2006, nine pilot projects were established. That year, a CSH Coordinator was hired at ADH as a counterpart to a CSH Coordinator at ADE. In 2007, the ADH Tobacco Prevention and Cessation Program entered into a collaborative partnership with ADE to provide funding for an additional twenty-three school districts. At present, 33 school districts are involved in CSH. As part of Arkansas Act 180 of 2009, funds were allocated to establish 8-10 new school-based wellness centers. Only schools participating in the CSH initiative were eligible to apply for wellness center funding. In the spring of 2010, nine schools were selected to establish wellness centers, with implementation to proceed during the 2010-11 school year. As part of its continued support for CSH, ADH will soon hire a clinical coordinator to assist these schools in operation of wellness centers.

Other Child and Adolescent Health activities include grief counseling for parents of infants determined at autopsy to have died of SIDS. Title V funds support a small stipend to the State Medical Examiner's (ME) Office for provision of autopsies and autopsy information on babies who die suddenly and unexpectedly (usually at home). By Arkansas law, such infants should be transported in every case to the ME's Office for post-mortem examination. When a determination of SIDS is made, autopsy results are forwarded to CAH staff and parental counseling through the local health unit public health nurse is offered. A recently noted trend is that the ME is applying stricter criteria before making a determination of SIDS. Therefore, fewer babies have a death determination of SIDS, and more are being signed out as "sudden and unexplained infant death" (SUID). The Family Health Branch has recently been working with the ME's office in support of its efforts to train county coroners in proper infant death scene investigations.

Lead poisoning prevention carries no designated funding in Arkansas at present. Blood lead screens are conducted by private physicians in accordance with state and federal EPSDT rules. CAH provides occasional information to providers and parents on lead risks, and occasionally helps arrange for an environmental investigation when a child is found to have a significant blood lead elevation. However, such occurrences have become extremely rare in the state. Recent screening data from Arkansas Children's Hospital suggest that the Medicaid population has only about a 0.3% prevalence of blood levels of >=10mcg/dL, with no levels exceeding 12 mcg/dL in the past year of screening at that institution.

At the local level, Title V provides support for a number of nursing and clerical positions working in local health units. These individuals provide WIC and Immunizations services, the chief child health services provided at the local level. At the state level, the WIC Program is administered through a separate branch in the Center for Health Advancement, while the Immunizations

Program is conducted under the Infectious Diseases Branch in the Center for Health Protection. All staff members at the local level fall under the authority of the Center for Local Public Health, which is administered through five Regional Offices.

Although not part of Child and Adolescent Health, the Office of Oral Health (OOH) is an important ally in child health. OOH envisions Arkansas as a state where everyone enjoys optimum oral health through primary prevention at the community, health care professional and family levels. OOH believes this goal can be accomplished through accessible, comprehensive, and culturally-competent community-based oral health care provided through a variety of financing mechanisms; educational opportunities throughout life that will allow individuals to make better decisions for their health; and informed and compassionate policy decisions at all levels of government. In addition to improving dental health for infants, children, and adolescents, the Oral Health Office also strives to help adults and the elderly.

Description of Services: OOH colleagues provide education and awareness on a variety of oral health issues including fluorides and fluoridation, dental sealants, infection control, oral cancer, access to care, tobacco cessation and prevention, and family violence prevention. OOH assists communities with water fluoridation through community presentations and providing funding through the Arkansas Dental Foundation. Working with the Division of Engineering, OOH provides water plant operator trainings throughout the state. Working through the Arkansas Oral Health Coalition, OOH provides dental sealants to at-risk children. OOH has recently partnered with Arkansas Children's Hospital to provide both preventive and restorative care through utilization of three ACH mobile dental vans that traverse the state. OOH colleagues conduct a wide variety of assessment activities throughout the state on children, adolescents and the elderly. Reports on the various assessment activities are available and are combined into an oral health burden document. OOH also continues to support proposed legislation that would mandate fluoridation for all the state's public water systems.

3. Primary and Preventive Services for Children with Special Health Care Needs

Target population: Children and youth 0-21 years old with chronic illness, disabling conditions, or other special health care needs

Description of Services: The Title V CSHCN program provides direct health care services to approximately 500 children and youth in any given year who have applied for assistance in paying for eligible services. These services include coverage of diagnostic evaluations prior to subsequent eligibility determination being made. Many of the applicants are subsequently found to be ineligible for ongoing coverage due to being financially ineligible or diagnostically ineligible. Assistance in helping pay for the diagnostic services, the Title V CSHCN program is able to alleviate some of the financial burden felt by families who may be newly bombarded by special needs issues. Referrals are made for other programs for which the individual or their family may be eligible. The coordination and payment of those services is accomplished by 4 Registered Nurses. The billing and payment for those services is extremely labor intensive. Alternative means of paying for services have been explored, but would not provide a remedy to the amount of detailed billing that is required. Approximately 19% of those children and youth are undocumented and do not qualify for Medicaid because of their citizenship status. Therefore, the Title V CSHCN program has assumed the cost of care that is typically covered by Medicaid. Approximately 21% of the budget goes to those services. As funding allows, the Title V CSHCN program assists with families of eligible children and youth covered by Medicaid by paying for items or services not covered by the Medicaid state plan. Approximately 180 Medicaid recipients received assistance in the form of payment for items or services over the past year. Some of the assistance was for the purchase of van lifts, wheelchair ramps, overhead lift systems, and compounded drugs. In addition, the program has assisted in payment for attendance at Med-Camps during the summer. Attendance at these camps allows time for peer interaction and socialization while teaching diagnosis-specific self care in a fun, camp environment. The Title V CSHCN program set aside funds for a Family Support/Respite program. This program can

provide assistance to families whose child has been determined disabled according to the SSI or TEFRA standards and whose care involves a service that is not covered by any existing program. The family can submit an application in which they detail the level of care required for their child in six areas of daily living. A physician must sign and verify that the parent has correctly outlined the level of care required for the child. Upon receipt, the application is reviewed for eligibility with a minimum number of deficits required to become eligible for the program. The services that can be provided are items (e.g. weighted vests, nutritional supplements) or services (e.g. respite). Last year the Title V Family Support/Respite program provided assistance to 354 CSHCN.

Title V staff provide Medicaid-reimbursed care coordination assistance to approximately 1,700 CYSHCN and their families. The Medicaid recipient must be medically eligible for the Title V CSHCN program unless the individual is under age 16 and receives SSI or TEFRA benefits. Those recipients may request and receive Title V CSHCN care coordination assistance regardless of whether the diagnosis qualifies them medically for the program. The Title V CSHCN program cannot bill for care coordination assistance if any other program or provider is working with the family and billing Medicaid for care coordination. The Title V CSHCN staff consists of Registered Nurses and Social Workers trained as a Title V CSHCN care coordinator and a medically trained Secretary who has received training and experience in care coordination. A broad-based knowledge of programs and providers of services in the state and local community allows Title V CSHCN staff to make appropriate referrals in a timely manner. Some of these referrals are for Special Needs Funds and Integrated Supports, DDS programs that provide timely relief to families with emergency needs. Title V CSHCN personnel also make referrals and assist with applications for the ACS Home and Community Based Waiver. This task requires a great deal of time and, typically, multiple contacts with the parent/guardian and other entities to obtain the information required for the application. The waiting list for the ACS Waiver is quite long and Title V CSHCN workers are often contacted when emergencies occur due to behaviors at school and/or home. The CSHCN team works in concert with other DDS programs to assist the family in obtaining services for immediate needs.

Mental health services for children and adolescents in Arkansas come from a variety of sources. Many private providers, particularly those with inpatient facilities, receive state assistance to help care for emotionally and behaviorally disturbed youth. Inpatient programs often have specific treatment units for issues such as substance abuse, sexual offenses, mood disorders, and various forms of psychosis. These providers work closely with regional CASSP coordinators and local CASSP teams, including Title V CSHCN program staff, to determine the most appropriate placement of affected children and youth within the state network of providers. The CASSP Coordinating Council, consisting of representatives of mental health providers, regional CASSP coordinators, and other agencies including Title V CSHCN, meets monthly to share information and discuss system issues. A more recent infrastructure-building effort is the System of Care initiative being carried out by Division of Behavioral Health Services within DHS. Two pilot sites, Independence Co. (Batesville) and Garland Co. (Hot Springs), have already implemented the model, which includes a number of "wraparound" services for severely troubled youth in an effort to address individual needs in a holistic manner. Preliminary evaluation of pilot sites suggests great success with youth served in this way, and plans are to expand the model to other communities as funding permits.

By agreement with Arkansas Social Security Disability Determination Services office, information is forwarded to the Title V CSHCN program when they receive an application for SSI on any child or youth less than 16 years of age. Upon receipt, CSHCN staff review each referral to determine if the individual is already receiving Title V CSHCN services. If not, further referrals are made for other services/programs for which the individual may also be eligible, such as Part C Early Intervention, DDS programs and Behavioral Health services. Approximately 2,000 such referrals are received during any given year.

4. The WIC population

The mission of the Women, Infant and Children program (WIC) is to improve the health of infants, children and childbearing women by directly supplementing their diets with foods rich in nutrients they need, providing nutrition education and counseling and referrals to other services. The mission of WIC Farmers' Market Nutrition Program (FMNP) is to encourage the consumption of fresh fruits and vegetables by WIC participants and encourage the development of farmers' markets.

Target Population: Pregnant, breastfeeding and postpartum women, and infants and children under age five are eligible if they live in Arkansas, are income eligible and have a condition or living situation which places them nutritionally at risk. Income eligibility is based on 185% of the federal poverty guidelines. For FMNP, women and children who are WIC participants in the counties with authorized farmers' markets are eligible.

Description of Services: Risk Assessment - a screening to determine nutritional status is performed on each applicant by a nurse, nutritionist, home economist, or physician.
Food: WIC participants receive nutritious, prescribed foods and purchase these foods as listed on WIC checks (bank drafts) at local grocery stores. The WIC food package was updated in October 2010 to include the addition of fresh and frozen fruits and vegetables, soy beverages, whole grains, and infant foods. FMNP participants receive coupons, not to exceed $12, to purchase locally grown fruits and vegetables at farmers' markets.
Nutrition Education:
•Nutrition Counseling --Participants with potentially serious nutrition-related health problems are scheduled for individual counseling by nutritionists.
•Nutrition Education --All participants or parents of participants are offered nutrition education designed to improve health status and achieve positive change in dietary and physical habits.
•Breastfeeding Promotion and Support --All pregnant women are informed of the benefits of breastfeeding their infants. Breastfeeding women receive support services from trained health providers and may receive breast pumps.
Referrals to Other Services: WIC participants are referred to other services as needed by local clinic staff. Strong emphasis is given to childhood immunizations and prenatal care.

5. Women and men of reproductive ages (Family Planning)

The purpose of the Reproductive Health Program is to provide reproductive health services to women and men, enabling them to choose the number and spacing of children and prevent unplanned pregnancies. Reproductive Health services include health history assessment, laboratory tests, physical assessment, contraceptive methods, health education, treatment and referral. Clients are also strongly counseled on immunization needs. The Reproductive Health Program has implemented health records specifically for male clients seeking reproductive services. These services are available to all Arkansas residents at 84 Local Health Units (LHU) and one (1) contracted agency.

Target Population: Men and women of childbearing age in the State of Arkansas, primarily low-income clients who are uninsured and under-insured. Priority populations include teens, minorities, low income women, women without insurance, and unmarried women.

Description of Services: The Reproductive Health Program provides, through ADH and delegate agencies, clinic based family planning services to women and men in need of publicly supported services. Eighty percent of clients are at or below 200% of poverty according to declared income and family size. In addition, the program provides outreach and education to hard-to-reach populations regarding family planning. This includes education on abstinence and male responsibility. The program also detects precancerous and cancerous changes of the uterine cervix through Cervical Cytology Screening.

The Reproductive Health Program is a Title X Grantee. The program also benefits from the

Women's Health Waiver, which is a Medicaid 1115 Waiver Program for family planning services in Arkansas. All women of reproductive age that have incomes at or below 200% of the federal poverty level are eligible for the waiver.

6. Target population: Medicaid Recipients

The Health Connections Section (HCS) in Family Health, through a toll-free hotline, communicates with new enrollees in Medicaid to link the children to a Primary Care Physician (PCP), and to case manage them for initial dental appointments. Up-to-date lists of physicians, dentists, and enrollees are maintained by Medicaid and HCS is provided with updated computer databases to track and inform newly enrolled families. HCS also provides through its health education staff community based outreach education to promote Medicaid use by adolescents in the school setting.

C. Organizational Structure

Since July 1, 2007, when the Arkansas Division of Health separated from the Arkansas Department of Health and Human Services to again become the Arkansas Department of Health (ADH), great strides have been made in restoring agency infrastructure. The State Health Officer, Dr. Paul Halverson, reports directly to the Governor as a Cabinet member. ADH is now organized into five primary Centers: Health Advancement, Health Protection, Public Health Practice, Local Public Health, and the Public Health Laboratory (see attached ADH organizational chart). The Family Health Branch is located within the Center for Health Advancement, along with four other branches: Nutrition/WIC, Oral Health, Life-stage Health, and Chronic Disease. Within each branch, various sections carry out specific programmatic and administrative functions. The Family Health Branch contains three sections: Women's Health, Child and Adolescent Health, and Health Connections.

Title V CSHCN program activities have historically been housed within the Arkansas Department of Human Services (DHS). DHS is a large separate agency whose director, Mr. John Selig, also reports directly to the Governor (see DHS organizational chart, second page of attachment). DHS consists of ten major divisions. The Title V CSHCN Program is housed within the Division of Disabilities Services (DDS). The director of this division is Charles Green, PhD. DDS also contains administrative units for Early Intervention Services (Part C) and direct and coordinating services for children and adults with developmentally challenging conditions.

Administration of Title V grant activities is therefore a collaborative process within the state of Arkansas. As the primary grantee, ADH apportions funds to the CSHCN Program at DHS based on a mutually agreeable formula. Program personnel from the two state agencies work together throughout the funding cycle to assure that grant funds are expended in accordance with federal and state requirements.

An attachment is included in this section.

D. Other MCH Capacity

The Family Health Branch Chief position was recently vacated by Dr. Richard Nugent, who had served as Director of Maternal-Child Health Activities at ADH for almost 18 years (see attached

branch organizational chart). In anticipation of Dr. Nugent's retirement, recruitment for this position has been underway for some time, and a replacement is likely to be named very soon. Mr. Bradley Planey, a long-time ADH administrator in family planning and current Associate Branch Chief, has recently accepted the role of Interim Title V Director. Mr. Planey holds an MS in Rehabilitative Counseling, an MA in Human Resource Development, and an MA in Health Services Management and has previous career experience in rehabilitative services. Dr. Bob West, a board-certified pediatrician with over 15 years experience at ADH, serves as Deputy Chief for Family Health. Dr. West has a Master of Public Health degree (MPH) and has past experience both in academic medicine and in medical care for those with severe developmental disabilities. Data analysis for MCH is provided by Ms. Terri Wooten, an epidemiologist housed in the Health Statistics Branch who recently completed work on her MPH degree. Ms. Wooten has been invaluable in providing statistics and analysis related to the Block Grant, Needs Assessment, and any other MCH data needed for special projects such as infant mortality reduction.

Other MCH data support is provided by various analysts in the Health Statistics Branch (HSB). This branch manages data from birth and death certificates, hospital discharge, PRAMS, BRFSS and local YRBS databases. HSB also manages professional registries for licensed health professionals. HSB maintains a staff of highly skilled statisticians who are trained in SAS software use. They assist epidemiologists and program directors with data needs for agency performance, strategic planning, and program registries such as cancer and immunization. The HSB manages the State Systems Development Grant (SSDI) which supports a rich network of data linkages being developed by the Arkansas Health Department. For example, SSDI and other resources have enabled HSB to link birth certificates to infant death certificates, hospital discharge data, PRAMS survey data, Medicaid enrollment and billing information, and a variety of other data sets.

MCH capacity for populations of interest are described below.

1. MCH capacity for pregnant women and infants

The Perinatal Program is a part of the Women's Health Section within the Family Health Branch. The Perinatal Program provides support and guidance to the public health units through research, policy development, and directing and assisting implementation of program policies and procedures. Women's Health Perinatal staff includes a chief physician consultant (Dr. Michael Riddell), who is board certified as a Fellow of the American College of Obstetrics/Gynecology, and a Section Chief (Sharon Ashcraft), a BSN Registered Nurse with extensive experience in maternal child care and public health. A total of 11 staff members at the state level support Women's Health program administration, which includes both maternity and family planning operations. At the local level, Advanced Practice Nurses and Registered Nurse Practitioners, along with the public health nursing staff, provide direct clinical services in accordance with program guidelines.

2. MCH capacity for children

The Child and Adolescent Health (CAH) Section of the Family Health Branch houses children's health programs. Ms. Millie Sanford, a licensed audiologist with a Master of Science degree, who has served children in this agency for over 15 years, was appointed Section Chief for CAH in March 2010. As before, Family Health Branch leaders expect the Section to continue emphasizing development of interagency collaboration and broad partnerships in improving services for children. Heavy use of MCH Block Grant dollars to sustain the immunization program continues, but greater emphasis is being brought to Coordinated School Health, Early Childhood Comprehensive Health Systems, and newborn metabolic and hearing screening. A total of 25 nurses, program managers, audiologists, and administrative and clerical staff currently carry out CAH functions at the state level. Funding for these positions comes from a variety of sources: newborn screening fees, MCH Block Grant, state general revenue, federal categorical grants for

infant hearing, and a cooperative agreement with the Arkansas Department of Education (for Coordinated School Health).

3. MCH capacity for Children with Special Health Care Needs

The Title V CSHCN program (formerly known as Children's Medical Services or CMS) currently resides within the Division of Developmental Disabilities Services (DDS) at DHS. Ms. Nancy Holder, an RN with many years experience in CSHCN service delivery, directs the program. Ms. Holder and Iris Fehr, RN oversee the work of nurse care coordinators serving children with a variety of medical conditions (e.g. diabetes, cancer, severe asthma, orthopedic conditions, spina bifida, and/or cystic fibrosis). Eldon Schulz, M.D., with the University of Arkansas for Medical Sciences Department of Pediatrics, serves under contract as Medical Director for the Title V CSHCN program. His professional background is in Developmental-Behavioral Pediatrics.

The Title V CSHCN program currently has on staff: 18 Clerical Staff, 15 Registered Nurses, and 6 Social Workers in community-based offices. There are six Management staff with two housed in community-based offices and four in the central office. There are eleven Central Office support staff (administrative and clerical). Of the 55 total employees, seven have children/grandchildren with special health needs. One is the Parent Consultant, three are Clerical staff, two are Registered Nurses, and one is a Social Worker.

Rodney Farley serves as Parent Consultant for the Title V CSHCN program. In this position he serves on a number of committees as a parent of a child with special needs and as an advocate. The committees he serves on include Partners for Inclusive Communities (Arkansas' Center for Excellence in Disabilities) Consumer Committee; Arkansas Parent Information Exchange; Arkansas Children's Hospital Rehab Advisory Committee; Family to Family Health Information Center Governing Board; AR Can-Do Committee. He serves on the board of directors for the AR State PIRC/Center for Effective Parenting; and the Board of Directors of the Disability Rights Center (Arkansas protection and advocacy services for people with disabilities). Nationally he serves as co-chair of the AMCHP Family and Youth Leadership committee. Rodney works with the Title V CSHCN Parent Advisory Council (PAC). As the parent of a young adult with special health care needs, he is able to give advice and assistance to parents with children of all ages. The Parent Advisory Committee (PAC) for the Title V CSHCN program was formed 20 years ago and involves volunteers from around the state that are parents of CSHCN. The PAC meets quarterly. The PAC members are responsible for setting up local meetings to take information to more parents and work to set up support groups around the state.

4. WIC services

As mentioned, the WIC Program is a separate branch within the Center for Health Advancement. WIC clinic services and food instrument services are provided in all local health unit sites. In addition, three WIC-only sites (in Springdale, Fort Smith, and Lowell) also provide services. Ms. Susan Handford, a nutritionist and experienced WIC administrator, is the interim director for WIC following the retirement of the former director. The WIC Program is supported by the Center for Local Public Health, which assures program operations through Regional Directors and Local Health Unit Administrators.

An attachment is included in this section.

E. State Agency Coordination

State agency coordination exists on many levels, including 1) among state government human service agencies, 2) through state-level commissions and other state-level partnerships, 3) through state-local health agency relationships, and 4) via local human services agency interactions. Each of these categories of coordination is discussed separately.

1. State government human services agencies

The three main human service agencies - the Arkansas Department of Health (ADH), the Arkansas Department of Human Services (DHS), and the Arkansas Department of Education (ADE) - are all cabinet-level agencies whose directors report to the Governor. As sister agencies, cooperation and collaboration are expected by the Governor and Arkansas Legislature, to the fullest extent possible.

The most obvious example of coordination between ADH and DHS relative to MCH services is, as previously described, the collaboration needed to carry out Title V with activities split between the two agencies (see attached MOA). Another specific example of collaboration between ADH and DHS is the contract with the DHS Division of Medical Services (Medicaid) to support the ConnectCare program, which is conducted by the ADH Health Connections Section. ConnectCare links new and established Medicaid participants with primary care physicians and dentists. The program also provides helpful information to Medicaid beneficiaries through a newsletter and other educational tools. The Medicaid Family Planning Waiver is another collaborative activity. This expansion of eligibility affords family planning services to women who previously would not have qualified for Medicaid. Family Health staff members contribute parts of the required triennial renewal application and participate in quarterly conference calls. Other agreements between ADH and DHS that are smaller in scope also abound, but are equally important. For example, a memorandum of agreement between the ADH Infant Hearing Program and the DHS Early Intervention (Part C) program provides for exchange of follow-up information after babies diagnosed with hearing loss are referred to Part C.

As for ADE, a number of working relationships with ADH also exist. Part of ADH's appropriation from the tobacco master settlement funds goes toward employment of 23 Community Health Nurse Specialists (CHNSs) and Community Health Promotion Specialists (CHPSs). The CHNSs are primarily involved in tobacco use prevention in schools and communities, while the CHPSs focus more heavily on anti-obesity efforts related to Arkansas Act 1220. Although employed by ADH, the CHNSs and CHPSs are housed in the 15 Education Service Cooperatives around the state per agreement with ADE. ADH also provides funding to support the ADE School Nurse Consultant, who receives co-supervision by ADE and ADH. The Coordinated School Health Coordinator position housed at ADH is funded by the Arkansas Department of Education, but supervised by ADH alone. A similar position to coordinate clinical activities at the newly established school wellness centers is also being created. It is anticipated that this position will be funded by ADE but housed and supervised by ADH.

2. State-level commissions, and other state-level partnerships and advocacy groups

Among many such groups, a few stand out as being particularly important. One longstanding partner is the Commission on Child Abuse, Rape and Domestic Violence. Among many other activities, this group has worked to establish a child fatality review process in Arkansas. Members of the ADH Family Health team have participated in these efforts. The Child and Adolescent Service System Program (CASSP) strives to improve the system of care for children and youth with mental and behavioral health issues. Dr. West serves on the CASSP Coordinating Council, which meets monthly. Another group, the Interagency Coordinating Committee (ICC) was established for IDEA and continues to help state agencies collaborate around the educational and health needs of at-risk children. Finally, the non-profit Arkansas Advocates for Children and Families has played a major role over the years in public policy for the needs of children in general. Arkansas Advocates' personnel serve on a large number of important interagency commissions, coalitions, and other state-level planning groups.

Another important state-level group is the Arkansas Early Childhood Comprehensive Systems partnership, which has devoted much effort to development and implementation of a Quality Rating System (QRS) for child care and early childhood education providers. A five-tiered QRS

for all aspects of child care and early education that includes a comprehensive set of criteria for health issues has, after thorough review by important stakeholders, been settled upon. The Division of Child Care and Early Childhood Education (DCCECE), the licensing unit within DHS, has assumed leadership for applying these voluntary guidelines. Until his recent retirement, Dr. Nugent served as co-chair for the AECCS Medical Homes Committee, which has nearly completed development of a medical homes "tool kit" for use by child care providers. In addition to Medical Homes, other AECCS committees include Social/Emotional, Early Childhood Education, Family Support, and Parent Support subgroups. Providing oversight to the entire AECCS process is the newly established Arkansas Early Childhood Partnership. Finally, a related state-level body is the Early Childhood Commission (ECC), which provides guidance to DCCECE. Dr. West currently serves on the ECC as the ADH representative.

The Child Health Advisory Committee (CHAC) was created through Arkansas Act 1220 of 2003 to address childhood obesity and develop statewide nutrition and physical activity standards. The Committee, which is now staffed by the LifeStage Branch within the ADH Center for Health Advancement, meets monthly and makes policy recommendations to the State Board of Education and the State Board of Health. Major tasks mandated by the original Act include: 1) Removing elementary school student in-school access to vending machines offering food and beverages; 2) Developing recommendations to ensure that nutrition and physical activity standards are implemented to provide students with the skills, opportunities and encouragement to adopt healthy lifestyles; 3) Requiring schools to include as part of the annual report to parents and the community the amounts and sources of funds received from competitive food and beverage contracts; 4) Requiring schools to include an annual measurement of body mass index (BMI) percentile as part of each student's health report to parents; and 5) Requiring schools to annually provide parents an explanation of the possible health effects of body mass index, nutrition and physical activity. The Committee includes state-level representation from public schools, nutrition, pediatrics, public health, family medicine, physical activity, cooperative extension service, school nurses, the PTA, child advocates, and other relevant groups. The CHAC has seen many of its recommendations translated to policy within the education system. As a result of amendments to Arkansas Act 1220 in 2007, CHAC is now also charged with providing guidance for the Coordinated School Health Program. Another amendment that year changed the frequency of BMI measurements in schools to every other year (even-numbered grades K-10). Dr. West serves as the ADH representative to CHAC.

The Natural Wonders Partnership Council is yet another major interagency coordinating and advocacy effort underway. Initially envisioned by the leadership at Arkansas Children's Hospital (ACH), the effort has grown to include virtually all groups at the state-level with an interest in improving child health status. ACH now has full-time staff dedicated to continuing the process, which began with a multi-pronged statewide needs assessment in 2007. Since then specific action groups for such issues as infant mortality, oral health, and coordinated school health have blossomed and continue to thrive. ADH has had representatives on all of these groups; for example, Dr. Jennifer Dillaha, former Director of the Center for Health Advancement, has chaired the infant mortality action team. Natural Wonders assessment and intervention activities are described further in the 2010-15 Needs Assessment document.

CSHCN Commissions, partnerships, advocacy groups: Located within the Arkansas Department of Human Services in the Division of Developmental Disabilities Services, the Title V CSHCN program works closely with providing early referral to children and youth for programs within the Division that will provide services throughout their lifetime. This includes the Alternative Community Services Waiver (commonly known as the DDS Waiver) which will provide services within the family home and in alternative environments such as alternate family placements. Title V CSHCN staff also provide information and assistance in obtaining services for youth that are aging out of our program through independent living situations such as group homes and apartments. The Title V CSHCN staff also works with other Divisions within DHS to obtain services for CYSHCN. Referrals for enrollment with a Medicaid Primary Care Physician are completed with assistance from the Division of County Operations as well as referral for Medicaid

applications. Our staff is able to access the data system within that Division, ANSWER, and subsequently follow the progress of the applications. The Title V CSHCN program is also an active participant in the Assuring Better Child Development (ABCD) III project coordinated between the Division of Medical Services and the Division of Child Care and Early Childhood Education. In addition, Title V CSHCN personnel are active in the Arkansas Early Childhood Care and Services (AECCS) program as members of the Partnership Council. CSHCN staff members have served on committees on Medical Home with Medicaid and also with AECCS to expand the understanding and utilization of the standards of the Medical Home in program development. Statewide Title V CSHCN staff members are active participants in the local Hometown Health Initiative teams within the Arkansas Department of Health. Title V CSHCN personnel also participate on the Oral Health Coalition, a group of programs and agencies, public and private, that have the common goal of increased provision of oral health services to all Arkansans. The Office of Oral Health in the Arkansas Department of Health is the driving force behind the coalition.

The state's only medical school, the University of Arkansas for Medical Sciences (UAMS), offers many broad contributions to health care within the state. ADH has a multi-faceted relationship with UAMS, with both formal and informal partnerships at many levels. Perhaps the most significant example relevant to MCH is that Dr. Nugent served his entire tenure as MCH Director at ADH via contract with the UAMS Department of OB/GYN. Other specific examples of formal agreements include a contract with the UAMS Department of Pediatrics to provide subspecialty consultation to ADH in follow-up to abnormal newborn screening results, including housing a newborn screening coordinator within the Genetics Section; a memorandum of agreement with UAMS Partners for Inclusive Communities (PIC) to promote sickle hemoglobin trait counseling services offered through PIC; a technical services agreement with UAMS College of Allied Health Professions to provide audiological diagnostic services in follow-up to newborn screening in six sites; and a contract with the Department of OB/GYN to provide prenatal care for high-risk patients referred from local health units.

Also under the auspices of UAMS is the College of Public Health (COPH), which was established in 2002. The COPH includes the shared missions of 1) meeting the public health workforce needs for the future and 2) demonstrating how public health approaches can address the health needs of Arkansans via model community programs. Pilot sites for teaching and learning also serve as innovative laboratories for new and creative approaches to old problems. Degrees currently offered include the MPH, the DrPH (Public Health Leadership), and two PhD's (Health Policy and Management, and Health Promotion and Education). The COPH is accredited by the Council for Education in Public Health. Many ADH leaders are active as adjunct faculty and are involved both in teaching and research through the College.

Also connected to UAMS is the Arkansas Center for Health Improvement (ACHI), whose mission is to provide relevant research on needs in Arkansas and on relevant public health practices, and to facilitate translation to action. ACHI is staffed by UAMS faculty and other employees, and is under the direction of Dr. Joe Thompson, who also serves as Arkansas's Surgeon General. One example of ACHI activities is the collection, analysis, and reporting of BMI data collected from school children as a result of Arkansas Act 1220. In general, ACHI serves as a resource center and think tank which provides valuable recommendations to the Arkansas Board of Health and other public health entities in the state.

A final UAMS initiative of special significance to MCH is the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning System) project, which has received generous support via federal Medicaid dollars (Center for Medicare and Medicaid Services). ANGELS has attempted to promote development of a more regionalized system of perinatal care in the state to assure that care for high-risk pregnancies and deliveries takes place in appropriate centers. The project has also developed a large number of specific practice guidelines for use by prenatal and neonatal care providers. Telemedicine networks for both obstetric and neonatal providers have been established, with routine videoconferences now conducted. Support for local providers

through remote consultation featuring such services as real-time interpretation of fetal ultrasounds has also been provided. Dr. Nugent was heavily involved in the program's research efforts as a member of the Core Evaluation Team, and it is anticipated that his successor will be similarly involved. Several scientific papers related to ANGELS have either been published or are in process at this time.

3. State-local health agency relationships

The Arkansas Department of Health is a highly centralized structure. Unlike some states, local health departments have limited autonomy in Arkansas. Local health unit (LHU) activities are largely managed through the Center for Local Public Health, which has five regional offices that provide more direct day-to-day guidance for LHU operations. Clinical activities with programmatic management based within the Center for Health Advancement and Center for Health Protection (WIC, Maternity, Immunizations, etc.) are conducted in LHU's. Because of this, there is a need for internal coordination with Local Public Health. Center leaders meet regularly at Senior Staff meetings and also informally as needed. Two other forums also exist to help Centers collaborate. The Scientific Advisory Committee develops and assures the use of the public health evidence base to support the assessment, policy and assurance functions of the ADH. Also, the Doctors' Horizontal Team provides links among agency medical professionals including physicians, dentists, veterinarians and other doctoral-level personnel.

Hometown Health Improvement (HHI) is a process designed to empower local communities to identify and focus on issues of local importance. Although supported by the Arkansas Health Department, HHI is considered to be locally owned and locally controlled. HHI coalitions exist in every county of the state, although some are more active than others. Typically, the local health unit administrator is a driving force in sustaining a community coalition, but in some cases already-existing local initiatives have been brought under the HHI umbrella. HHI has state-level coordination that supports local groups through data collection and interpretation, assistance with coalition-building, dissemination of information, training, and evaluation. Examples of activities undertaken by local coalitions include tobacco cessation for adolescents, household hazardous waste removal, local industry wellness, health fairs, parenting support groups, and health resource guides. Community members have participated in training sessions on community assessment, coalition-building, and effective partnership-building.

Other examples of state-local partnerships are the Unwed Births Prevention program and the Abstinence Education Program. In each of these initiatives, community organizations applied for subgrants from ADH under a request-for-applications process. Last year funds were awarded to four county coalitions for Unwed Births and to six community-based organizations for Abstinence Education. Although these projects have since been discontinued due to lack of funding, a similar model may be applied in future years as new funds emerge for teen pregnancy prevention. One other major state-local partnership started in late 2009 is the STAR Health initiative. This effort attempts to marshal additional health, economic, and educational resources to combat health problems in three southeast Arkansas counties: Chicot, Desha, and Lincoln. A steering committee composed of state and local community representatives meets regularly. Nine lay community health workers have been hired to provide outreach to vulnerable individuals, and Americorp volunteers have been enlisted to provide community-level awareness. Community providers from private and public sectors have become engaged, and funding support from a variety of sources (state and private foundations) has been received. Goals of STAR Health include reduction of infant mortality, teen pregnancy, and chronic disease; improved education outcomes; and sustained economic development for the three counties.

4. Local human service agency interactions

As a result of Hometown Health Improvement, a number of robust partnerships have been formed in many communities across Arkansas. HHI coalitions typically include representation from local public health, community health centers (if present), hospitals, county government,

private medical providers, public schools, business interests, non-profits, county DHS office, and other interested parties. As described above, these coalitions have gathered local data, chosen priorities, and implemented local strategies to tackle health problems.

Local coordination also occurs in response to public health exigencies. One example is influenza vaccination for school-age children. When the Governor placed a line item in the SFY2010 budget calling for flu vaccination to be offered to every child in the state in the fall of 2009, local health units partnered with local schools to ensure a seamless delivery of service to school children. Since this planning was already underway when the novel H1N1 flu virus appeared, the addition of H1N1 vaccine to the process was only minimally disruptive. Much credit for the stunning success of this initiative goes to the local cooperation exhibited between health and education providers.

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicators primarily assess, in a general fashion, how well state programs such as Medicaid, SCHIP, and CSHCN are meeting the needs of those eligible for such services. They also assess Title V programs' ability to access relevant data sources and linkages. While CSHCN data are quite accessible to the Arkansas program, Medicaid and SCHIP data require a formal request through the Medicaid agency (housed in the Arkansas Department of Human Services). In the past year, the state Medicaid agency has imposed additional requirements on ADH for such requests. A need exists to have routine Title V-related data requests placed at a higher level of priority within the Medicaid data system's analytical priorities. Negotiations between ADH and Medicaid senior leadership are ongoing in this regard.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.9	22.3	22.3	23.3	18.1
Numerator	504	430	430	471	365
Denominator	187377	192891	192891	202070	202070
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

Data source: Hospital Discharge Data System, Health Statistics Branch, ADH and US Census Bureau.

2009 indicator pre-populated with 2008 data, as 2009 Hospital Discharge data is not available.

Notes - 2008

Data source: Hospital Discharge Data System, Health Statistics Branch, ADH.

2008 indicator pre-populated with 2007 data, as 2008 Hospital Discharge data is not available.

Notes - 2007

2007 indicator pre-populated with 2006 data, as 2007 Hospital Discharge data is not available.

Narrative:
Asthma hospitalizations among young Arkansas children appear to be down, but as in the past, these data need to be interpreted with caution. According to experts in pediatric asthma care within the state, under-recognition of childhood asthma by primary care physicians continues to be a major problem. When hospitalized, children with asthma may often be mistakenly diagnosed with another condition, such as "bronchitis" or "pneumonia." Better education and training of primary care physicians is needed to assure proper diagnosis and treatment of children with this very common health issue. The UAMS Department of Pediatrics has taken the lead in providing continuing medical education on the subject, but perhaps more intensive training during residency is also warranted as a long term strategy.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	63.2	75.2	75.5	61.8	84.9
Numerator	15932	20544	22003	19915	24251
Denominator	25225	27311	29146	32205	28555
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: FY 2009 Medicaid claims.

Notes - 2008
Data source: FY 2008 Medicaid claims.

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

Notes - 2007
Data source: FY 2007 Medicaid claims.

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

Narrative:
The apparent marked improvement for this measure in 2009 compared to 2008 is likely due in part to data issues for the 2008 reporting year, a year in which many Medicaid measures showed unexpected results. Some true improvement undoubtedly has occurred, but since at least six preventive health visits in the first year of life are recommended, it remains troubling that 15% of eligible infants failed to receive even one.

The state Medicaid Program has made a conscious push in the past year to promote well-child

visits through the EPSDT program. The Medical Home Work Group of the Arkansas Early Childhood Comprehensive Systems process has developed educational materials aimed at both child care providers and parents of young children that discuss the need for preventive care through a medical home. ADH Family Health Branch staff members (Chief and Deputy Chief) have helped draft and review these materials as part of their work on the group. In southeastern Arkansas, the STAR Health project in May 2010 initiated direct provision of EPSDT screens to infants and young children in local health units in the three counties involved (Lincoln, Chicot, and Desha). If successful there, ADH may consider expanding these services to other counties. A major barrier to provision of such services in local health units is that a referral is required from the child's physician for every visit. State Medicaid has retained this policy in defense of the concept of the medical home.

The Health Connections Section within Family Health has promoted the need for well-child visits to parents at various venues including health fairs and at schools. Particularly, the Section has taken the opportunity to stress the need for these visits at kindergarten "roundups" where parents come to the school to pre-enroll their children.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	8.0	61.4	62.7	17.6	72.3
Numerator	66	522	602	165	579
Denominator	823	850	960	939	801
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: FY 2009 Medicaid claims.

Notes - 2008
Data source: FY 2008 Medicaid claims

Then number of children less than one year who have received at least one periodic screen in 2008 is difficult to accept based on previous years' data. We are currently attempting to communicate with the Medicaid Program to ask about double checking this number or providing an explanation of why the number is so much lower that previous years' numbers. As of this date, we have not been able to obtain this information.

Notes - 2007
Data source: FY 2007 Medicaid claims

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

Narrative:

As with HSCI 2, major problems in Medicaid data from 2008 make comparisons to that year shaky; however, compared to 2006 and 2007 some improvement has been seen in this measure. Because Arkansas has its own Medicaid expansion plan in place (ARKids B), there are few enrollees labeled as true "SCHIP." Nonetheless, the improvement seen parallels that for the entire infant Medicaid population, although the total percentage is not as high. Efforts of the state Medicaid program in promoting well-baby visits seem to be helping. Still, the fact that almost 28% of SCHIP infants failed to receive even one preventive health exam in 2009 is unacceptable. A possible strategy is to allow local health units to perform EPSDT screens without PCP referrals in communities where PCP's are in short supply and/or are willing to cede their EPSDT duties to ADH. However, such a plan would require approval by state Medicaid.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	79.0	79.1	81.0	80.3	80.6
Numerator	30755	31697	33425	32969	31555
Denominator	38937	40061	41248	41046	39150
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data source: Birth Certificate Data, Health Statistics Branch, ADH

These data are reported for October 1, 2008 through September 30, 2009.

Notes - 2008
Data source: Health Statistics Branch, ADH

These data are reported for October 1, 2007 through September 30, 2008.

Notes - 2007
Data source: Health Statistics Branch, ADH

These data are reported for October 1, 2006 through September 30, 2007.

Narrative:
ADH continues to support the Healthy Baby/Happy Birthday Baby Book. a program that encourages all pregnant women to receive early and continuous prenatal care. In 2009, a total of 12,047 books were provided to Arkansas's pregnant women, with an additional 88 out-of-state requests. The Health Connections Section, through a contract with Arkansas Medicaid, works to connect Arkansas Medicaid recipients to healthcare providers and health resources in their community. This activity is performed by helpline operators who staff a telephone toll free helpline. The helpline operators' primary function is to assign Medicaid and ARKids recipients to a primary care physician and provide dental case management.

The Arkansas Department of Health continues direct provision of maternity services. There has been an increased number of Medicaid prenatal providers which has reduced the demand for local health unit prenatal services in some areas. ADH now provides prenatal services in 54 Local Health Unit sites in 49 counties as compared to 61 sites in 55 counties in 2008. Local Health Units continue to work with their communities and providers to ensure pregnant women have access to prenatal care. Clients are screened for presumptive eligibility Medicaid; given information on, and referrals to, medical providers; and afforded access to other ADH services. The Local Health Units saw 4357 pregnant women for their initial prenatal appointments in CY2009, of which 2241 (51.4%) were seen in their first trimester.

ADH continues to serve the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse or domestic violence seek the non-judgmental care of the local health unit. Local Health Units provide pregnancy testing for women who want to confirm their pregnancy or those seeking pregnancy.

The Perinatal Health Program oversees the Lay Midwife (LMW) Program. Currently, there are 30 Licensed Lay Midwives and 14 Lay Midwife Apprentices. The choice to use a lay midwife for home birth may provide a viable alternative to maternity care in Arkansas, particularly for low risk pregnant women. LHU's provide risk assessments and referrals, as needed, for the LMW clients.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	98.5	85.0	97.2	97.2	93.4
Numerator	450332	345512	464845	464845	453397
Denominator	457214	406494	478052	478052	485331
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: FY 2009 Medicaid claims.

Notes - 2008
2008 indicator is prepopulated with 2007 data due to inability to obtain this information from the Medicaid Program.

Notes - 2007
2007 rate is percent of Medicaid enrollees who have received a service paid for by the Medicaid Program.

Narrative:
This indicator has dropped off slightly since 2007, but still reflects fairly robust utilization of Medicaid services by those enrolled in the program. Most Medicaid beneficiaries seem to be aware of many services available. However, the Health Connections Branch within ADH Family

Health has been involved in educating families about the wide variety of these services through parent newsletters, other mailings, and phone calls.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	42.7	43.6	46.5	38.8	59.3
Numerator	38842	34517	37557	47915	50004
Denominator	90958	79094	80681	123588	84283
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: FY 2009 Medicaid claims.

Notes - 2008
Data source: FY 2008 Medicaid claims.

Narrative:
As with certain other indicators, Medicaid data from 2008 are questionable and comparison of 2009 with prior year figures seems more advisable. The proportion of Medicaid children in this age group receiving dental services seems to have risen significantly overall between 2005 and 2009, an encouraging trend. Access to dental providers is a major issue in Arkansas, particularly for children. Dentists are not located in sufficient quantity in many parts of the state, tending to be clustered in the largest population centers. Not all dentists accept Medicaid patients either. In addition, many parents probably still fail to recognize the need for routine preventive dental care in childhood.

The Office of Oral Health (OOH) has partnered with Arkansas Children's Hospital (ACH) in provision of direct preventive and restorative dental services via three mobile dental vans owned and operated by ACH. OOH has supplied a dental hygienist to work side-by-side with ACH dental providers in these vans as they traverse the state, often setting up shop at or near school settings.

The Health Connections Section within Family Health has been involved in encouraging parents to seek dental care for children through such events as health fairs and kindergarten "roundups."

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	40.5	44.7	51.1	36.8	32.2
Numerator	7427	8658	10066	7410	7752

Denominator	18344	19382	19714	20143	24074
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
There has been a readjustment downward in the numerator to levels similar to 2004 and 2005. Cases are placed in an inactive status if there is no response from the family after repeated contacts in an attempt to better reflect current activity.

Notes - 2007
2007 data: renewal of relationships with families of CSHCN covered by SSI has led to an increase in this indicator in the past 2 years.

Narrative:
One-third of SSI beneficiaries in Arkansas receive services from the Title V CSHCN program. Children's Services staff provide services to children and youth that receive SSI benefits in the form of case management/care coordination services through information, referral and advocacy. Individuals that have not requested case management assistance are eligible to receive services in the form of newsletters giving pertinent information to the families, invitation to apply for Title V Family Support/Respite funds, assistance in applying for Home and Community Based Waiver, information on transition issues and, as funding allows, assistance in the purchase of equipment not covered under the Medicaid state plan.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	10	7.2	8.9

Notes - 2011
Data source: Provisional 2008 linked Birth/Hospital Discharge Data System file.

Narrative:
Although historically a very frustrating problem, Arkansas continues with previous efforts to curb the occurrence of low birth weight. A focus on teen pregnancies has been included in outreach efforts of the local health units. Teens are at risk for premature deliveries and low birth weight infants. Among states with available data, Arkansas had the highest pregnancy rate among non-Hispanic white teenagers (67 per 1,000) and one of the highest overall rates for teen pregnancy. Unfortunately, teen births, poverty levels, single parent households and unemployment rates in Arkansas are above national rates, all of which can affect pregnancy outcomes. The percentage of ADH local health unit maternity patients on Medicaid for 2009 was 77.2%, with 18.7% of

patients uninsured. The Infant Mortality Action Group continues to identify and advise on activities that could reduce LBW and infant mortality.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2008	matching data files	7.1	4.4	5.9

Notes - 2011
Data source: Provisional 2008 linked Birth/Infant Death/Hospital Discharge Data System file.

Narrative:
Medical costs for over half of all births in the state of Arkansas are covered by the Medicaid Program. Infant mortality rates are higher for the Medicaid-served population than for non-Medicaid, reflecting the toll exacted by poverty and other social ills more prevalent among the Medicaid group. Poor access to preventive and primary services for some individuals, especially people of color living in particularly underserved regions of the state, is surely a contributing factor. In addition to race, poverty alone is an important determinant for the observed disparity. This statement is supported by a linked birth-infant death cohort analysis using 2008 data showing infant mortality rates of 6.8/1,000 among white Medicaid infants and 3.4/1,000 among white non-Medicaid infants. Whites in Arkansas account for about two-thirds of all Medicaid births. On the other hand, the same analysis reveals much higher infant mortality rates among African Americans, both Medicaid and non-Medicaid, confirming that race itself is an independent risk factor. Interestingly, and in contrast to Whites, Medicaid appears to be a protective factor for African American infants, with infant mortality rates of 9.4/1,000 for those on Medicaid, and 14.1/1,000 for those not on Medicaid.

Encouraging decreases in the overall infant mortality rate have occurred over the past 2-3 years. The Family Planning Waiver has demonstrated success in reducing unintended pregnancies. Medicaid eligibility expansion to 200% of poverty for pregnant women several years ago may have also played a role. The ANGELS prenatal and neonatal care improvement effort out of UAMS has shown success in reduction of deaths to very low birth weight neonates whose mothers were covered by Medicaid. On the other hand, death rates among Medicaid infants of mildly low birth weight (2000 to 2500 grams) have been noted to be persistently higher than those of non-Medicaid babies in the same weight range. Socio-economic determinants may be particularly relevant in this weight range of infants, who generally would not be expected to require prolonged stays in intensive care nurseries.

Reduction of infant mortality remains a key priority of ADH that arose from the 2008 strategic planning process. In the past one and a half years an Infant Mortality Action Team has been meeting under the auspices of the Natural Wonders Partnership both to catalog and coordinate existing efforts and to discuss potential new collaborative approaches.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	69.7	89.4	78

Notes - 2011
Data source: Provisional 2008 linked Birth/Hospital Discharge Data System file.

Narrative:
The Center for Health Advancement and the Center for Local Public Health (CLPH) continue collaborative efforts to serve pregnant women in local health units inicluding provision of referrals to Medicaid providers. The number of women served for maternity has decreased this year, with a slight reduction in the number of ADH local health units and counties providing prenatal services. Reductions may be the result of an increased number of Medicaid providers accepting clients early in their pregnancy. Other counties provide services for high risk clients until transfer for delivery due to a lack of providers accepting Medicaid clients. ADH local health units are focusing on enrollment in Medicaid for pregnant women through collaborative efforts with local DHS offices. Local health units continue to use appointment reminders by using a statewide system based in the CLPH. Happy Birthday Baby Books were provided to Arkansas's pregnant women that include advice and guidance for health pregnancy outcomes. The Health Connections Section through a ConnectCare contract with Arkansas Medicaid works to connect Arkansas Medicaid recipients to healthcare providers and health resources.

The ADH Centers for Health Advancement and for Local Public Health continue to assess the needs related to underserved pregnant women. In the five Public Health Regions, LHU sites are evaluated for the need to increase access to maternity services. Among women seeking prenatal care through their local public health units in CY2009, 51.4% (2241/4357) initiated prenatal care during their first trimester and 77.2% had Medicaid coverage. The lack of health care coverage, whether public or private, adversely affects the entry of women into prenatal care. ADH public health clinics are a key source of prenatal services for women without health care coverage. Other providers throughout the state, mainly UAMS AHEC's, also provide care to clients regardless of income or insurance coverage. Other providers charge a sliding scale fee for services, while ADH does not charge the maternity patient more than a $5.00 record maintenance fee for the visit.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 *Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State*	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	71.9	77.7	74.4

Notes - 2011
Data source: Provisional 2008 linked Birth/Hospital Discharge Data System file.

Narrative:
At 74%, the Kotelchuck Index for all pregnant women prenatal visits in the state represents a slight decrease compared to 2007. This is of concern when the possible negative impacts on infant mortality, pre-term deliveries and low birth weight infants are considered. The number of ADH local health unit sites providing maternity services has decreased to 54. ADH is reviewing targeted areas of the state with poor access to care and opportunities to improve this disparity. The STAR Health Initiative is one of the newly implemented activities to try to address this need. The Center for Health Advancement and the Center for Local Public Health (CLPH) continue efforts to serve pregnant women in the local clinics and provide referrals to Medicaid providers. The number of women served for maternity has decreased this past year, with a slight reduction in the number of ADH local health units and counties providing prenatal services. Reductions may be the result of an increased number of Medicaid providers accepting clients early in their pregnancy. The Health Connections Section through a ConnectCare contract with Arkansas Medicaid works to connect Arkansas Medicaid recipients to healthcare providers and health resources.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2009	200

Narrative:
The 2009 Arkansas General Assembly approved an increase in the eligibility limit for ARKids B from 200% FPL to 250% FPL. The expansion was to be funded through a new tax on tobacco products and was scheduled to go into effect on July 1, 2009. Unfortunately, budgetary constraints forced the state Medicaid Program to defer implementation. During SFY10 there have been three governor-ordered reductions in budget for state agencies, and the Medicaid Program is currently experiencing a severe shortfall. Although the program has expressed a desire to implement the expansion, only time will tell when it will be fiscally feasible to do so.

One aspect of health coverage expansion that is sometimes overlooked is the need for primary care providers to care for newly enrolled beneficiaries. Since there are already a number of locales in Arkansas (and elsewhere) with too few primary care physicians relative to the need, alternative approaches to primary care will have to be undertaken. Providers such as advanced

practice nurses and physician assistants may play an important role. The Arkansas Department of Health may also have to consider once again providing gap-filling services in some areas such as EPSDT.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 18)	2009	 133 100 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 4) (Age range 5 to 9) (Age range 10 to 18)	2009	 200 200 200

Narrative:
See discussion under HSCI 06A. In Arkansas, the income eligibility limit for "Medicaid" (ARKids A) changes at age six (not five as shown above). However, the top income for ARKids B (in effect, "SCHIP") eligibility is 200% for children of all ages (0-18).

The Family Health Branch continues to support efforts of the Finish Line Coalition and other groups to promote expansion of eligibility to more children in the state.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2009	200

Narrative:
See discussion under HSCI 06A and 06B. As with ARKids B, income eligibility for pregnant women was supposed to have increased from 200% FPL to 250% FPL in July 2009. However, budgetary concerns forced the Medicaid Program to place the expansion on hold for the foreseeable future.

Pregnant women under 200% FPL may qualify for presumptive eligibility and begin receiving medical services immediately under regular Medicaid while a determination of qualification is made. Women of the same financial standing who are resident aliens (not U.S. citizens) may

qualify for SCHIP PW benefits. Unborn children of such women are recognized under SCHIP rules as being entitled to coverage as future U.S. citizens at birth (assuming the mother intends to deliver the baby on American soil). Women who may ultimately receive SCHIP PW benefits do not qualify for presumptive eligibility benefits.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
As in the past, birth defects surveillance system data are not directly accessible to MCH staff. These data are housed in the UAMS-run Arkansas Center for Birth Defects Research and Prevention. ADH has an agreement to share data from Vital Records with the Center. Clinical birth defects data from the Center are provided to the ADH Health Statistics Branch, which then supplies birth and or death certificate information back to the Center. A research file with identifiers removed assists reporting and research requirements of both institutions.

Many other data systems are readily accessible to the MCH program, such as PRAMS, behaviorial risk factor survey (BRFSS), hospital discharge, birth and death records, cancer registry, and newborn hearing and metabolic screening. Linkage of birth records with newborn

screening data occurs at least semi-annually, with additional or special reports available on demand. The new infant hearing electronic data system set to be implemented in 2011 will be fully integrated with birth certificate records, with common data for both to be entered just once while the infant is in the hospital nursery.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco Survey	3	Yes

Notes - 2011

Narrative:
Although there is no direct access to the full YRBS database, more in-depth information, if needed, can often be obtained through county- and school-district level YRBS surveys performed in conjunction with the Coordinated School Health initiative. The Youth Tobacco Survey also affords a wealth of information from specific community settings around the state.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The process to determine priority needs for pregnant women and infants, children, and (non-pregnant) women began with a thorough review of data relevant to health issues of these groups. An MCH Needs Assessment Planning Team was established which consisted of leaders from the Perinatal Health and Reproductive Health Programs within Women's Health, the Child and Adolescent Health Section, and the Office of Oral Health. In the spring of 2009, the Team organized a group of external stakeholders representing all three sub-interests that included community, academic, and state agency participants. After relevant data were presented to the three sub-groups, a master list of potential priorities was then generated and narrowed further using a group process.

Priorities for Children with Special Health Care Needs were established using a separate process. The CSHCN Program partnered with the LEND (Leadership Education in Neurodevelopmental and related Disabilities) program at UAMS to help coordinate needs assessment activities. Surveys were mailed to 2,500 families served by the CSHCN Program in early 2010. In addition, a total of 11 community forums were held in cities and towns around the state during 2009-10. Attendees at these forums were allowed to participate in a "voting" process to identify issues of greatest import. Additionally, a focus group was organized to solicit input from local and regional CSHCN staff.

Through these processes, various Stakeholders suggested the following set of priority issues for pregnant women and infants, children, and non-pregnant women:
1. Increased EPSDT screening rates
2. Access to the medical home
3. Care coordination for children, including use of human service workers in schools
4. Increased provision of dental screening, sealants, and water system fluoridation
5. Enhanced parent health literacy
6. Creation of school-based wellness centers
7. Childhood injury prevention
8. Prevention of teen pregnancy
9. Lifestyle/behavioral changes to improve pregnancy outcomes (alcohol use, smoking, oral health, etc.)
10. Access to prenatal/intrapartum care
11. Services for infants (e.g. immunizations, well-baby)
12. Chronic disease self-management for women
13. Reduction of Chlamydia infection rates
14. Health disparity reduction (non-traditional approaches)

The CSHCN Stakeholder groups recommended the following potential priorities:
1. Increased communication regarding available CSHCN programs and services
2. Improved access to a trained and knowledgeable Title V CSHCN workforce
3. Development of a more accessible diagnostic infrastructure within the state to assure early diagnosis and treatment of developmental disabilities
4. Other - DDS Waiver issues, education and school problems, availability of training, transportation difficulties, respite care (or lack thereof)

During the year following the 2009 MCH stakeholder meetings, other potential priorities also emerged through ongoing partnership activities. These included: 1) enhanced training for first responders in the CDC's Sudden and Unexpected Infant Death Investigation (SUIDI) process; 2) establishment of an infant death review process; 3) reduction of smoking among women of childbearing age; 4) tobacco use among adolescents (as measured through Coordinated School health activities); 5) improved developmental and social-emotional screening of young children; and 6) enhanced screening of post-partum women for depression (possibly to be conducted as a

Region VI joint priority).

The MCH NA Planning Team carefully considered these suggested priorities throughout the duration of the Needs Assessment process. Clearly, many of the areas suggested are already addressed through national performance measures, health status indicators, and health system capacity indicators. The Planning Team factored in analysis of many data elements from the needs assessment as well as ongoing state efforts and capacity in arriving at the following final list of state priorities for the coming five years:

-Reduce births to older teens
-Reduce smoking among women of childbearing age
-Improve trauma care for children
-Improve oral health in children and women
-Reduce obesity and overweight among school-aged children
-Improve communication between the Title V CSHCN program and the CSHCN population
-Improve training and program development for the Title V CSHCN workforce

These priorities and accompanying state performance measures are discussed further in the next section.

B. State Priorities

Each of the selected state priorities will be discussed in detail.

1. Priority: Reduce births to older teens

SPM 1: The rate of birth (per 1,000) for teenagers aged 18 through 19 years

This priority links to NPM 8, births to teens 15-17 years old. Arkansas has traditionally had higher rates of births to teens, although actual pregnancy rates among teens are similar to the national average. Part of the rationale for the selected priority and SPM is that Arkansas has the highest rate of births to 18-19 year olds, according to rankings released by the Guttmacher Institute in 2010. Although they are older adolescents, most 18 and 19 year olds are not financially, developmentally, or emotionally prepared to be parents. Many interventions effective for younger teens will impact 18 and 19 year olds as well. Finally, only 38% of Arkansas youth who start college actually graduate, and unintended pregnancy during the first years of college may well be an important contributor.

Arkansas has numerous resources at hand to continue to combat births to teens. ADH is the largest public provider of family planning services in the state, with confidential services available to both female and male youth in every county. Community Health Centers, AHEC's, Planned Parenthood, and other private providers (e.g. physicians' offices) also provide a fair share of services. Although Unwed Births Initiative and Abstinence Education activities were suspended in mid-2009, substantial new federal teen pregnancy prevention funds have recently been announced, and the state intends to actively pursue those. Re-authorization of abstinence-only education funds also affords a potential avenue to pursue. The recent establishment of school wellness centers linked to the Coordinated School Health process creates additional venues for teen pregnancy prevention activities, even if direct family planning services are not provided on campus.

Other opportunities for intervention related to this measure include increased outreach to colleges and universities within the state. Currently ADH operates satellite family planning clinics at two colleges. In addition, more local health units could be encouraged to offer family planning services at alternative hours (nights, weekends) targeted specifically to teens, as is currently

done in three counties. Finally, and perhaps most importantly, the Medicaid Family Planning Waiver could be better publicized to encourage more young women to take advantage of covered services.

2. Priority: Reduce smoking among women of reproductive age

SPM 2: The percentage of women aged 18-44 years who report being current smokers

Smoking has many well-documented adverse consequences throughout the reproductive years and beyond. In addition to increasing risk for many types of cancer and for chronic lung disease, smoking is a major risk factor for cardiovascular disease. Smoking during pregnancy is associated with lower birth weights, major obstetrical complications, and higher risk of SIDS. The detrimental effects of secondhand smoke on children are also myriad. According to an analysis published in MMWR in December 2009, compared to other states Arkansas had the eighth highest rate of smoking-attributable mortality among females during 2000-2004. The female smoking-related mortality also increased in Arkansas when compared to 1996-1999.

This priority is related to NPM 15, women who smoke during the last 3 months of pregnancy, but is much broader in scope. Data on smoking trends among Arkansas women are available through the Behavioral Risk Factor Surveillance System. This telephone survey is conducted annually and is scientifically weighted to reflect the state as a whole.

Resources to combat smoking among Arkansas women are very robust. The ADH Tobacco Prevention and Cessation Program (TPCP) supports the statewide Stamp Out Smoking initiative aimed at both primary prevention and cessation of smoking. Many anti-tobacco programs and curricula are based in schools, particularly Coordinated School Health Schools that receive TPCP funds. An ongoing media campaign involves ads on TV, radio, and in print media. TPCP sponsors the Arkansas Tobacco QuitLine, a toll-free telephone helpline for free tobacco cessation counseling, nicotine cessation medication (depending on availability), and information on state and local resources to help Arkansans stop using tobacco. The Arkansas Tobacco Quitline provides a special tobacco cessation program with extended services designed for pregnant and postpartum women.

Within ADH Women's Health programs there exists additional capacity to discourage smoking. While Women's Health Nurse Practitioners are very well-informed and engaged in promoting smoking cessation in maternity and family planning clinics, public health nurses (PHN's) are typically less so. An opportunity exists to train more PHN's in smoking cessation and to institute policy changes that would make cessation-related referrals and follow-up by PHN's more routine.

3. Priority: Improve childhood trauma care

SPM 3: The proportion of children aged 0-21 with injury severity score of >15 who receive definitive treatment at either a Level I or Level II trauma hospital

This priority ties to NPM 10, deaths to children 0-14 due to motor vehicle crashes. Unintentional childhood injury death rates in Arkansas have traditionally greatly exceeded national rates, often by 50% or more. In addition to motor vehicle crashes, causative events for which the state suffers excess childhood mortality include house fires, drowning, and unintentional firearm injuries. Lack of public awareness and the rural nature of much of the state have often been blamed for these deaths. Many have also pointed to historic lack of a statewide trauma system as being an important factor.

An exciting recent development is the appropriation of almost $20 million in state funds toward creation of a statewide trauma system. Many committees and subcommittees consisting of a multitude of internal and external stakeholders have been working the past year to lay out the structure of the new system and determine needed resources to make it work. A new Trauma

Section has been established within the ADH Injury Prevention and Control Branch to oversee the system, and a director to head up the new section was recently hired. When fully operational, the trauma system should improve transport times and allow for assignment to the most appropriate trauma care facility based on the nature of the injury. The Injury Severity Score is calculated using the Abbreviated Injury Scale (AIS) assigned in the field and is a useful indicator of the severity of injury. The AIS is utilized for most children with more severe injuries and is information that will be collected through the state Trauma Registry housed within the Arkansas Department of Health. As the trauma system unfolds, more children with severe injuries should be appropriately triaged and dispatched to higher level care facilities. Therefore, the above state performance measure should serve as a reasonable indicator for how trauma system development is progressing with respect to childhood injuries.

4. Priority: Improve oral health in children and women

SPM 4: The percentage of people on community water systems whose water is appropriately fluoridated

This priority is related to NPM 9, percent third grade children with dental sealants. Oral health in Arkansas has been a continuing challenge for many years due to lack of and maldistribution of providers and a relative lack of fluoridated water supplies. Children in the state suffer more dental decay than in many states, and women also feel the effects of cavities and periodontal disease. Although the issue goes well beyond water fluoridation, progress in that arena should serve as a correlate for improved dental health overall.

Data for the new state performance measure will be obtained from the ADH Office of Oral Health (OOH), which has been very involved in promoting fluoridation of public water supplies. As a partner to OOH, the Arkansas Delta Dental Foundation has contributed many thousands of dollars to fund needed equipment and supplies for community water systems that elect to fluoridate, and now 65% of Arkansans on such systems receive water with recommended levels of fluoride. Legislation to mandate fluoridation of all public water systems has been drafted and introduced several times but to date has not passed. In the meantime, OOH has worked with individual systems to raise awareness and support for fluoridation, adding a number to the ranks of the voluntarily "fluoridated" over the past ten years. OOH has also partnered with a number of groups to provide and promote dental sealants in children.

5. Priority: Reduce obesity and overweight among school-aged children

SPM 5: The percentage of school-age children with body mass index >85th percentile

This priority represents a continuation of childhood obesity as an area of focus. However, the previous two state performance measures have been combined into a single measure. This measure is related to NPM 14, WIC children aged 2-5 years with BMI >85th percentile. Obviously, however, the targeted age range for this state measure is older than that for NPM 14. Arkansas is blessed to have available a large amount of BMI data from school-aged children, thanks to a requirement of Arkansas Act 1220 of 2003. The same act established the Child Health Advisory Committee, which is charged with recommending policies for schools in the state that will lead to reduction of child obesity. Many other interests in the state, such as the Arkansas Coalition for Obesity Prevention, also have a stake in seeing this problem improve. While rates of overweight/obesity among children have not declined significantly the past six years, they have leveled off and evidence of decline is expected shortly. Given the intense ongoing activity in this arena, continued focus is clearly warranted.

The other former state measure for obesity in children (% WIC children with wt/ht >95th percentile) has been dropped due to its close similarity to NPM 14.

6. Priority: Improve communication between the Title V CSHCN program and the CSHCN

population

SPM 6: The percentage of respondents indicating Title V CSHCN program personnel have communicated information on one or more program(s) or service(s) that was helpful in meeting a family or individual need within the previous year.

This priority ties to all five of the CSHCN NPM's. Data will be obtained from an annual survey with questions targeting the measure. Assistance from Departmental and other experts on survey development will be required. This measure should show an increase in subsequent years. Families indicated during focus groups and on the survey that they have a tremendous need for information. Members of the focus groups were dissatisfied that information on programs and services was not readily available to them in this age of instant access. Resources to improve communication with the families of CSHCN include the development of the program's website and improved quarterly newsletters.

7. Priority: Improve training and program development for the Title V CSHCN workforce

SPM 7: The percentage of CSHCN care coordination staff expressing unmet needs related to workforce development and/or training

This priority ties to CSHCN NPM's 4, 5 and 6. Data will be obtained from an annual survey of CSHCN staff with questions targeting the measure. Assistance from Departmental and other experts on survey development will be required. This measure should show a decreasing percentage over subsequent years. The Employee Focus Group expressed disappointment in the training resources available to them as they strive to serve the CSHCN community. In addition, new programs developed within short time constraints proved problematic and made it especially difficult for care coordination staff to manage and provide adequate and correct information to the CSHCN community. Workforce development and empowerment are an essential element to the quality of services provided to the CSHCN community. By improving the training and tools available to the CSHCN care coordination staff, the services provided to the CSHCN community will improve as well.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	98	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	44	46	33	47	60
Denominator	44	46	33	47	60
Data Source				Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Revisions were made to the Follow-up NBS Protocols to fit the Arkansas population. Cut-off values for conditions such as Congenital Adrenal Hyperplasia were adjusted. The protocols for all disorders were reviewed for standards of practice and updated accordingly.

An RN follow-up coordinator and a Nurse Program Manager were hired, completing staffing requirements for the expanded Newborn Screening Program.

Site visits continued to the birthing hospitals across the state by the NBS Nurse Educator to offer technical assistance with the goals of decreasing specimen rejection rates and improving timeliness of submission.

The Arkansas Genetic Health Committee bylaws were revised to allow the formation of three sub-committees: Newborn Screening and Laboratory Services, Pediatric Genetic Services Committee, and Adult Genetic Services Committee. The Newborn Screening Subcommittee began quarterly meetings in July 2009.

The Newborn Screening Program nurses at the Arkansas Department of Health continued to work closely with the Newborn Screening Coordinator at Arkansas Children's Hospital to coordinate follow-up care for babies with abnormal newborn screening results. Meetings were held bi-monthly to review and coordinate follow-up activities.

The Patient Care NBS Module of the PerkinElmer database was fully operationalized and use of paper patient files was essentially discontinued.

A Memorandum of Agreement was developed between ADH and UAMS Partners for Inclusive Communities to facilitate counseling of families whose infants are determined to carry a hemoglobin trait. The plan that was developed calls for ADH to include a Partners brochure (which describes the free service) in letters sent by the NBS Program to such families.

Plans were developed to establish a secure database for long term (5 year) follow-up of confirmed cases.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. An RN follow-up coordinator and nurse program manager were hired, completing program staffing requirements.				X
2. The Newborn Screening Subcommittee began quarterly meetings in July 2009, with a goal of improving NBS system quality.				X
3. The electronic follow-up module was fully operationalized and paper patient files were essentially discontinued.				X
4. Newborn screening follow-up protocols were reviewed and revised as needed to ensure all infants with positive results were tracked to diagnosis				X
5. Visits were made by the NBS Nurse educator to every birthing				X

hospital in the state to provide training and technical assistance in specimen collection				
6. A memorandum of agreement was developed between ADH NBS and UAMS Partners for Inclusive Communities to facilitate hemoglobin trait counseling				X
7. Partnerships with the UAMS Department of Pediatrics, including a contract for a NBS Coordinator to be housed there and for subspecialty genetics consultation, were formalized				X
8.				
9.				
10.				

b. Current Activities
The Nurse Educator has been offering training and technical assistance to individual hospitals needs during site visits to birthing hospitals. In particular, the rejection rates for newborn screening specimens are being closely followed and will be reviewed with the nursery and/or hospital laboratory staff as needed. All 46 birthing hospitals in Arkansas have been visited at least one time this year.

The Newborn Screening Subcommittee continues to meet quarterly. Topics of discussion include quarterly screening results, potential new disorders to be added to the screening panel, specimen retention, changes in assays and cutoffs for existing disorders, and approaches to coordination of care for infants with positive results.

The Follow-up NBS interpretation sheets, physician notification letters, and parent fact sheets were recently completely reviewed and revised in collaboration with metabolic specialists at Arkansas Children's Hospital. All are subject to frequent updates as necessary.

The Arkansas Newborn Screening web page is being enhanced to add more information and resources for parents and professionals and to provide additional contact information for the NBS program.

Screening analytes for tandem mass spectrometry-detectable disorders were recently reviewed and revised. Age-dependent cutoffs for congenital hypothyroidism screening are to be implemented this fiscal year, which should lead to fewer false positive results and reduce the possibility of false negatives.

c. Plan for the Coming Year
The NBS Subcommittee will consider steps needed to implement screening for new disorders, with Severe Combined Immune Deficiency receiving highest priority. The group will also work to recommend ADH policy concerning retention and possible uses of newborn screening blood spot specimens.

The NBS Nurse Educator will continue to visit all birthing hositals on a regular basis armed with hospital-specific data on reasons for specimen rejection. Emphasis on correct entry of specimen demographics will be paramount in the coming year, particularly given the move to age-dependent cutoffs.

The website will continue to be developed and expanded as resources allow.

Both laboratory and follow-up methodologies will continue to undergo intense study and updates as needed to ensure the most efficient, yet thorough, operation possible.

Partnerships with the University of Arkansas for Medical Sciences, Arkansas Children's Hospital, community hospitals, physicians, and other involved stakeholders will continue to be developed

through both formal (contracts, memoranda of agreement) and informal means.

Exploration of a means to allow primary care physicians access to individual newborn screening results via a secure web-based portal will proceed.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**38727**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	38164	98.5	68	1	1	100.0
Congenital Hypothyroidism (Classical)	38164	98.5	1449	25	25	100.0
Galactosemia (Classical)	38164	98.5	80	0	0	
Sickle Cell Disease	38164	98.5	17	17	17	100.0
Biotinidase Deficiency	38164	98.5	2	2	2	100.0
Cystic Fibrosis	38164	98.5	752	8	8	100.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	38164	98.5	16	1	1	100.0
Citrullinemia	38164	98.5	9	2	2	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	38164	98.5	468	2	2	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	38164	98.5	25	2	2	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	55	56	57	62	63
Annual Indicator	53.7	53.7	61.7	61.7	61.7
Numerator	12952	12952	468	468	468
Denominator	24116	24116	759	759	759
Data Source				Data from Nat'l CSHCN Survey, 2005-2006	Data from Nat'l CSHCN Survey, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	64	65	66	67	67

Notes - 2009
Indicator data is from the National Survey of CSHCN conducted in 2005 - 2006.
A statewide survey was mailed to parents/guardians of CSHCN in early 2010. 93.7% of the respondents indicated they are often or always included in their child's health care decisions. 66.1% indicated their child's health care team often or always listened to their concerns or questions. The same percentage indicated that the health care team asks that the parent/guardian share with them their knowledge and expertise as the parent/caregiver. However, only 32.1$ indicated that they were asked by the health care team how the child's condition affects the family (e.g. the impact on siblings, the time the child's care takes, lost sleep, extra expenses, etc.).

Notes - 2008
Indicator data is from the National Survey of CSHCN conducted in 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Data from our statewide survey completed in April 2008 was slightly higher at 65%.

a. Last Year's Accomplishments
The Title V Family Support/Respite program continued to provide assistance to families in the form of grants to purchase items or services required for their child's disability for which coverage was not available through any other funding stream. The program has brought many families to the attention of program staff that have been unidentified in the past.

The Title V Family Support/Respite program was changed to require the review and signature of a physician treating the CSHCN. This provided some assurance that information on the application was verified by an informed source. In-house processes to assure equity in evaluation of need were also put in place.
Title V CSHCN staff served as Intake and Referral staff for programs coordinated by the Division of Developmental Disabilities Services (DDS). Although this process involves assuring that families the program is familiar with apply earlier for the services (the Home and Community

Based Waiver coordinated by DDS, in particular), program staff are also brought into contact with individuals and families that have been unknown to the program in the past.

The CSHCN Program assisted in development of a Special Needs program for individuals diagnosed with Autism and implemented one-time funding utilizing state general revenue currently in place for an Autism Waiver (as yet un-approved) for family support services.

The CSHCN Program also assisted in development and implementation of a program to serve individuals of all ages with mobility impairments funded by the American Recovery and Reinvestment Act. Given the broad target group, children and youth with mobility impairments (e.g. Spina Bifida, Cerebral Palsy) unfortunately were competing with the aged population for funds.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN caseworkers referred to the Child & Adolescent Service System Program (CASSP) coordinators, participated on local & regional teams that work with youth with behavioral issues & serious emotional disturbance, and worked with local CASSP teams				X
2. CSHCN caseworkers worked with children & youth with developmental disabilities & their families via the Special Needs program to fund services not available elsewhere.		X		
3. CSHCN caseworkers provided referral to Integrated Supports program for children & youth with developmental disabilities in intense crisis situations and in danger of removal from the community to a restrictive environment.		X		
4. Title V Family Support/Respite program used to help meet a child or family's needs. Need established by level of care required, family income and disability determination by SSI or TEFRA.		X		
5. CSHCN Parent Advisory Council met quarterly with members coming from around the state to receive training, make program recommendations & share information with local parent support groups.				X
6. CSHCN staff assisted in development & execution of one time program to provide assistance to families of children diagnosed with Autistic Spectrum Disorder.		X		
7. CSHCN staff assisted in development & execution of ARRA program targeting individuals with mobility issues to assist with home and vehicle modifications.		X		
8.				
9.				
10.				

b. Current Activities

-Partnering with staff from ACH & AR Disability Coalition to seek grant funding for Family to Family Health Information Center. Grant funding was received & a part-time coordinator was hired & is housed with AR Disability Coalition.

-Part-time staff being hired using other parents of CSHCN as a resource in several areas of AR. CSHCN staff provide contacts to F2F HIC staff when responses are received from families giving

approval to share their name with other parents.

-Partnering with staff from Little Rock Air Force Base & Camp Aldersgate to develop & fund weekend respite services for CSHCN with parents active duty in the military. Families are far away from their support system & if a parent is deployed the other parent struggles. These families are not in-state long enough to qualify for Medicaid Waiver services & the respite care available with that program. 1 Title V CSHCN caseworker was assigned to serve as point of contact between the LR AFB personnel, the parent support group on base & the CSHCN program.

-Mail-out survey via the Title V CSHCN quarterly newsletter to assist in gaining information to assist in strategic planning & future program change. The use of the newsletter was a change & a response rate of 4.8% was much lower than in the past. Focus groups in 11 towns targeting parents/guardians, individuals with disabilities, providers of services & interested individuals. Flyers mailed to consumers, providers & interested individuals. 2 sessions @ each town

c. Plan for the Coming Year

1. Implementation of a strategic planning process with a review and assessment of services currently provided. If broadly scoped changes are indicated, the process to gain approval (either Divisional, Departmental or Legislative) will begin.

2. Continue provision of services as they are currently provided during the intervening time.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55	56	68	68	54
Annual Indicator	52.2	65.9	50.2	50.2	50.2
Numerator		120	379	379	379
Denominator		182	755	755	755
Data Source				This data comes from the National Survey of CSHCN	This data comes from the National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	53	57	59	60	60

Notes - 2009

This data comes from the National Survey of CSHCN 2005 - 2006.
In early 2010 a survey was mailed out to parents/guardians of CSHCN. The survey respondents answered the following questions on communication with the health care team. 71.4% answered

often or always that the health care team uses helpful ways to communicate with me (e.g. explaining terms clearly, giving out forms to help us prepare for our visits). 48.2% answered often or always that the health care team uses helpful ways to communicate with my child. 70.5% answered that the health care team often or always understands the family's needs and values. 58% answered that they often or always have someone to help them understand all of the child's health services. 58.9% answered that they can often or always get the health care that my child needs when we need it, including after office hours, on weekends and holidays.

Notes - 2008
This data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Our statewide survey response to the question "After reading about Medical Home, do you believe your child's primary care doctor meets the qualifications of a Medical Home?" had a "Yes" response of 84%.

a. Last Year's Accomplishments
The Parent Coordinator for the CSHCN program and members of the Parent Advisory Council have worked independently seeking grant funding to enable the Project DOCC program to continue to provide training to Medical Residents during their Pediatric rotation. The Program Director participated in work groups on Medical Home with Medicaid and the Division of Children and Family Services making plans for assuring that children in foster care would have a smooth transition between medical providers around the state using electronic medical records. The Program Director is an active member of the Medical Home work group for the Division of Child Care and Early Childhood Education. Development of tools that child care providers can use to learn about the Medical Home concept of health care and pass on that knowledge to the parents of the children they serve and the value of routine well child care, immunizations, dental care and developmental screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN staff provided information on Medical Home to families in a publication "You Are Not Alone" which was developed in conjunction with the Governor's Council on Developmental Disabilities		X		
2. CSHCN staff utilized a Medical Home display at consumer and professional meetings statewide providing brochures developed with grant funds in years' past.		X		
3. Program Director actively participated in Departmental workgroups on Medical Home targeting Early Childhood providers and foster children.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Partnering with:
1) Staff from ACH & AR Disability Coalition to seek grant funding for Family to Family Health Information Center. Grant funding was received & a part-time coordinator was hired and is housed with AR Disability Coalition. Part-time staff is being hired using other parents of CSHCN as a resource in several areas of AR. Title V CSHCN staff members provide contacts to Family to Family HIC staff when responses are received from families giving approval to share their name with other parents.
2) Working with staff from Little Rock Air Force Base & Camp Aldersgate to develop and fund weekend respite services for CSHCN with parents on active duty in the military. The families are far away from their support system and if a parent is deployed, the other parent struggles. These families are not in-state long enough to qualify for Medicaid Waiver services and the respite care available with that program. One Title V CSHCN caseworker has been assigned to serve as the point of contact between the LR AFB personnel, the parent support group on base, and the CSHCN program.

Conducted a survey via the Title V CSHCN quarterly newsletter to gain information that will assist in strategic planning and future program change. The use of the newsletter was a change and a response rate of 4.8% was much lower than in the past.

Focus groups were held in 11 sites targeting guardians, individuals with disabilities, providers of services, CSHCN employees and interested individuals.

c. Plan for the Coming Year
Implementation of a strategic planning process with a review and assessment of services currently provided. If broadly scoped changes are indicated, the process to gain approval (either Divisional, Departmental or Legislative) will begin.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	56	57	62	66	67
Annual Indicator	54.5	61.5	66.5	66.5	66.5
Numerator	103	112	493	493	493
Denominator	189	182	741	741	741
Data Source				Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	68	69	70	70	70

Notes - 2009
Data comes from the National Survey of CSHCN 2005 - 2006.
A survey was mailed to parents/guardians in early 2010. 75.9% answered often or always that "I have insurance to cover my child's health care services." 75% answered often or always to the statement "My child's health problems have an impact on our family." A supposition is made that financial impact is a portion of the family impact.

Notes - 2008
Data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Our statewide survey completed in April 2008 indicates that 65% of respondents state that insurance (public or private) covers the cost of their child's care. Yet on a question about out of pocket medical costs with 92 affirmative respondents, 47% paid from $1 to $1000 per year and 28% paid over $1000 per year out of pocket.

a. Last Year's Accomplishments
During the second year of the Title V Family Support/Respite program, applications were taken and evaluated at the local and regional level as caseworkers served families and became aware of the unmet needs of the child and family. During this year's program, other families new to the Title V CSHCN program became aware of and applied for the program as well. This provided the opportunity to share other information and resources. A total of 354 applications were approved in the amount of $320,000. In addition to this continuing program, Title V CSHCN staff members were responsible for the referral and intake for two additional programs through DDS. The Special Needs Autism program is a one-time program providing funding to the parent/guardian of children/youth diagnosed with Autism to assist families in paying for items or services needed strictly due to the diagnosis and not available through any other source. CSHCN personnel were required to process applications and forward for funding. Many applicants were unknown to Title V CSHCN staff and required additional documentation required to establish the diagnosis. Arkansas DHS was awarded funding through the American Recovery and Reinvestment Act and DDS received $1 million to assist individuals with mobility needs with the cost of home and vehicle modifications. The program was developed and implemented during Summer and Fall of 2009. Title V CSHCN staff made contact with everyone on their caseload who had a mobility impairment to assure they were aware of the availability of funds.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided payment for specialized care for approximately 300 CSHCN in combination with private health insurance at AR Children's Hospital, other local & regional hospitals and medical providers statewide.	X			
2. Provided payment in combination with private insurance providers for diagnostic workups on approximately 500 children who were suspected of having special health care need.	X			
3. Evaluated all applicants for the possibility of eligibility for other financial & disability categories of Medicaid.		X		
4. Provided payment for services for 181 Medicaid recipients that were not covered under the Medicaid state plan (purchase of medical equipment, van lifts, ramps, compound drugs, medical	X			

food for PKU, etc).				
5. Provided payment for Family support/Respite/Medical Camp for 394 CSHCN with Medicaid coverage.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A survey was mailed to parents/guardians in early 2010. 75.9% of parents/guardians responding to the Title V CSHCN program survey in early 2010 answered often or always to the statement "I have insurance to cover my child's health care services." 75% answered often or always to the statement "My child's health problems have an impact on our family." Financial impact is most likely a portion of the family impact. The Title V Family Support/Respite program process was changed during the third year and now requires a physician's signature verifying that the parent/guardian had accurately rated the abilities/needs of the CSHCN. Program staff felt this was necessary to assure that the service is available to those who are most in need. The Special Needs Autism program continued into this federal fiscal year. Since funding began, 340 applications were processed for a total amount of approximately $1.3 million. There is a waiting list with 71 names awaiting determination of whether there will be additional funds available for processing. The Home and Vehicle Modification program funded with ARRA money brought in applications on 111 children and youth. Of those, 59 have been funded at a total amount of $313,783.

c. Plan for the Coming Year

The strategic planning will continue and formal plans will be made for any changes in services provided by the Title V CSHCN program. Any changes made may require Divisional, Departmental and possibly Legislative approval. There are no anticipated changes for the Title V Family Support/Respite program.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	51	52	90	90
Annual Indicator	48.9	48.9	89.1	89.1	89.1
Numerator	64	64	688	688	688
Denominator	131	131	772	772	772
Data Source				Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
Data comes from the National Survey of CSHCN 2005 - 2006.
Although data for this measure was taken from the National Survey of CSHCN in 2005, the subject was addressed somewhat on a survey mailed to parents/guardians in early 2010. When asked to prioritize the needs of CSHCN in the state, the respondents ranked "community-based services organized so that families can easily access them" as the second priority behind the number one priority of "Adequate Health Insurance".

Notes - 2008
Data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
CSHCN staff members served on local, regional and state coalitions representing the special needs and developmental disabilities community. The groups include the Hometown Health Initiative, Interagency Coordinating Councils, CASSP (local, regional and state) the DHS Policy Workgroup, Arkansas Early Childhood Comprehensive Systems workgroup, the Oral Health Coalition, the Finish Line Coalition (statewide group whose focus is advocacy and outreach for health care coverage for all children), the Governor's Roundtable on Health Care and the Arkansas Genetic Health Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN staff served as care coordinators for children/youth & their families who have requested such assistance by completing an Individual Needs Assessment and Service Plan with the family.		X		
2. CSHCN staff served as the primary contacts for several programs within DDS and assisted in completion of and gathering of documentation that provided access to those programs and services.		X		
3. CSHCN staff represented the disability community on local councils and committees involved in development of local infrastructure (e.g. Hometown Health Initiative, CASSP, Interagency Coordinating Council).				X
4. CSHCN staff participated in public awareness activities by making visits to local medical providers, DHS offices and other local programs within the community to provide information on program services available.				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Although data for this measure was taken from the National Survey of CSHCN in 2005, the subject was addressed somewhat on a survey that was mailed to parents/guardians of CYSHCN in early Calendar Year 2010. When asked to prioritize the needs of CSHCN in the state, the respondents ranked "community-based services organized so that families can easily access them" as the second priority behind the number one priority which was "Adequate health insurance." CSHCN staff continue to serve on local, regional and state coalitions representing the special needs and developmental disabilities community. Two local CASSP teams were awarded System of Care grants to develop programs and processes to serve children and youth with serious emotional disturbance within their community. The Program Director serves on a newly formed Pediatric Genetic Health Committee. The Program Director serves on the Core Team for the ABCD Stakeholder's group and serves in the same capacity for the newly funded ABCD III grant awarded earlier this year. The focus of the grant is closing the referral loop on referrals for early intervention services.

c. Plan for the Coming Year

CSHCN staff will continue to work with local, regional and state service programs and agencies to make sure the needs of the CSHCN and their families are acknowledged.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11	11	15	34	35
Annual Indicator	10.5	10.5	33.1	33.1	33.1
Numerator	4	4	114	114	114
Denominator	38	38	344	344	344
Data Source				Data comes from the National Survey of CSHCN 2005	Data comes from the National Survey of CSHCN 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	36	37	38	38	38

Notes - 2009

Data comes from the National Survey of CSHCN 2005 - 2006.
A survey mailed to parents/guardians in early 2010 included statements related to transition:

"There is someone who has helped us or is helping us find adult care for my child" with a 32% "Yes" response rate and "We are making plans for the time my child becomes an adult" with a 52% "Yes" response rate. In addition, "Transition to adulthood" was listed as one of the "Services received from Title V Children's Services staff". A final question asked the respondents to prioritize the needs of the state's CYSHCN. Transition to adulthood was ranked last under (in order of the ranked priority by respondents) Adequate health insurance; community-based services organized so that families can easily use them; respite care; families as partners at all levels of care and satisfied with services; receiving coordinated, comprehensive, ongoing care within a medical home; and dental health.

Notes - 2008
Data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Our statewide survey mirrors the National Survey of CSHCN with a 33% response to question asking if there is a Transition Plan in place.

a. Last Year's Accomplishments
The Transition survey mailed to all CSHCN on the database in the month of their 14th birthday generated contact between the Title V CSHCN caseworkers and families on transition-related issues. CSHCN Program staff continued to provide Transition Tip Sheets to youth on their caseload. Title V CSHCN staff actively participated on the Arkansas Interagency Transition Partnership, a group representing agencies that provide services into adulthood with a focus on assuring that youth with special needs receive the assistance they need for education, job training and support, and living in the community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition surveys were received from YSHCN with responses that assist program staff in planning services.				X
2. CSHCN staff participated in AR Interagency Transition Partnership, a multi-agency committee working on transition issues.				X
3. CSHCN staff worked with individual YSHCN & local transition representatives to develop school transition plans.		X		
4. CSHCN staff worked in local Interagency Coordinating Councils to participate in Transition Fairs in the Dept of Education Regional Cooperatives.				X
5. CSHCN staff provided transition materials to all youth on their caseload receiving services at age 14 years and beyond.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Survey mailed to guardians of CYSHCN early Calendar Year 2010. Statements on the survey re: transition included: "There is someone who has helped us or is helping us find adult care for my child" and received a Yes response rate of 32% & "We are making plans for the time my child becomes an adult" and received a Yes response rate of 52%. "Transition to adulthood" was listed as one of "Services received from Title V Children's Services staff." A question asked the respondents to prioritize the needs of the state's CYSHCN. Transition to adulthood was ranked last under (in order of the ranked priority by respondents) Adequate health insurance; community-based services organized so that families can easily use them; Respite care; families as partners at all levels of care & satisfied with services; receiving coordinated, comprehensive, ongoing care within a medical home; & Dental health. In CSHCN staff experience, transition is not considered until a young person completes their public school education and they and their parent are confronted with "where to go now." The ability for the young person to function in society as an adult with all the legal rights and responsibilities of reaching the age of majority has not been considered in many families. A survey is mailed to CSHCN in the month of their 14th birthday to introduce the issue of transition & planning for adulthood. CSHCN staff actively participates on the Arkansas Interagency Transition Partnership (AITP).

c. Plan for the Coming Year

As strategic planning takes place, transition issues must be represented. There appears to be a need for regular communication during the transition period of life in which frequent reminders should be given to youth and their parent/guardian related to public school education issues, options for post-high school education, and employment opportunities. For some, the discussions also must include guardianship issues. Accessing tools that are in use in other states or the development of tools for CSHCN staff to use during this time period must be included in this work.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	85	87	88	80
Annual Indicator	83.4	86.8	79.4	77.9	83.0
Numerator	3269	3375	5848	6701	5812
Denominator	3921	3887	7363	8601	7000
Data Source				Vaccines For Children Program Co-CASA	Vaccines for Children Program Co-CASA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	84	84	85	87	88

Notes - 2009

2009 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at local health units and participating VFC private providers. The numerator is the number of children with coplete vaccine recores from those sampled.

Notes - 2008
Change in percent complete age appropriate immunizations for 2008 reflect addition of participating VFC private providers that provided immunizations to Arkansas children 19 to 35 months of age.

2008 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at local health units and participating VFC private providers. The numerator is the number of children with coplete vaccine recores from those sampled.

Notes - 2007
2007 data were changed to reflect addition of immunizations provided by participating Vaccines for Children (VFC) private providers.

2007 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at the local health units. The numerator is the number of children with complete vaccine records from those sampled.

The data are from ADH local health units and do not include private providers.

a. Last Year's Accomplishments
The Immunization Section, through each of ADH's local health units, routinely offered all vaccines necessary to age-appropriately immunize children. Each local health unit provided all immunization services and was able to identify children delinquent on needed doses of vaccine. Follow-up activities were initiated and designed to prompt parents/guardians to bring children into clinics to receive needed doses of vaccine.

Additionally, the Immunization Section's Vaccines For Children (VFC) regional colleagues promoted immunization activities in private physicians' offices throughout the state. These activities included conducting an assessment of patients' immunization status and providing technical assistance on follow-up activities with children to increase immunization rates. The Immunization Section, through the regional colleagues, continually solicited participation of all clinics, both public and private, to participate in the VFC Program thereby enabling the Arkansas Department of Health to expand availability of services across Arkansas.

The web-based immunization registry continued to enhance overall service delivery activities. It allowed public and private providers quick access to their patients' immunization records and real-time updating of individual immunization records. The Immunization Registry Team continued to place priority on training and recruitment of additional providers to utilize the registry.

During the fall of 2009 and with state funding, local health units worked with school personnel to conduct flu clinics in every public school in the state and in private schools upon request. An estimated 1,200 clinics were held and 329,792 doses of seasonal and H1N1 flu vaccine were administered.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All local health units provided currently recommended, age-appropriate vaccinations to infants and young children			X	
2. Parents were prompted to bring children in to local units for needed vaccinations through a variety of means		X		
3. Vaccines For Children regional staff worked with private providers to increase immunization rates		X		
4. The web-based immunization registry allowed rapid access by medical providers to children's immunizations status				X
5. Over 329,000 doses of flu vaccine were given in school flu clinics held during the fall of 2009			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Section, through ADH's local health units, continues to offer all vaccines necessary to age-appropriately immunize children. Follow-up activities designed to prompt parents/guardians to bring children into clinics to receive needed vaccines continue. Regional VFC workers continue to promote immunization activities in private physicians' offices throughout the state as above. Solicitation of additional clinics to participate as VFC providers is ongoing as well.

The Immunization Section continually works to attract more providers utilizing the immunization registry to make a more comprehensive immunization data base with immunization records readily available to both providers and parents. The immunization registry is web-based and currently 100% of the 585 providers report immunization information on a real-time basis or via batch downloads using HL7 to the registry via computers in their offices.

c. Plan for the Coming Year

The Immunization Section has in recent years implemented newer vaccines in ADH's immunization clinics such as the human papillomavirus (Gardasil), rotavirus, meningococcal (Menactra), pneumococcal for high risk children and adult pertussis (Tdap). In the coming year, policies will be put in place to employ the new 13-valent pneumococcal vaccine (PCV13) among young children. The use of these newer vaccines will be a high priority in ADH's local health units in an effort to reduce morbidity and mortality associated with these diseases.

The Immunization Section will continue to promote immunization of Arkansas's children through the Vaccines For Children (VFC) Program. The Section will identify areas in the state that have low immunization rates and intensify efforts to immunize individuals delinquent on receiving needed vaccines.

The Immunization Registry Team will continue to promote utilization of the web-based registry. The regional colleagues will continue to promote participation of all immunization providers in the VFC Program. Clinics will be assessed routinely to determine the age-appropriate immunization status of the children they serve so that steps can be taken to increase immunization rates.

School flu clinics are also again being planned for the 2010-2011 flu season. The Section will stay abreast of activities in other states and will implement those activities that have been proven to increase immunization rates.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	28	28	31	32	29.5
Annual Indicator	29.0	30.5	30.8	30.6	27.7
Numerator	1661	1796	1813	1780	1612
Denominator	57234	58842	58877	58092	58092
Data Source				2008 Birth Certificates	2009 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	27.5	27	26.5	26.5	26

Notes - 2009
2008 female population 15-17 years was used to compute 2009 rate.

Notes - 2008
2007 female population 15-17 years was used to compute 2008 rate.

The Abstinence Education and Unwed Birth Prevention activities, which are aimeed at teen pregnancy prevention, have been significantly cutback due to reductions in state and other funding. In addition, the Federal funds for abstinence education have been harder to utilize due the uncertainty and delayed disbursement of the funds from the federal government.

Notes - 2007
The Abstinence Education and Unwed Birth Prevention activities, which are aimeed at teen pregnancy prevention, have been significantly cutback due to reductions in state and other funding. In addition, the Federal funds for abstinence education have been harder to utilize due the uncertainty and delayed disbursement of the funds from the federal government.

a. Last Year's Accomplishments
The ADH Title X (family planning) program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By state law, priority is given to persons from low-income families. In 2009 the LHU's served 20,401 females and males under 20 years old for family planning services. Clients under age 20 totaled 26.4% of all family planning users. Local Health Units offered family planning services in every county, with an additional clinic opened in the NW Region. The Center for Local Public Health continued outreach to teens and vulnerable populations with over 500 outreach activities reaching over 71,000 persons.

Reproductive Health made educational presentations to community, civic and faith-based organizations; set up display booths at community health fairs; sponsored billboard displays promoting teen pregnancy awareness and clinic services; and participated in public affairs radio programs and interviews with local newspapers.

During State Fiscal Year 2009, ADH and the Unwed Birth Comprehensive Strategies Committee funded a limited number of community-level Unwed Birth Prevention Programs through a competitive RFA process. The purpose was to provide funds to local communities in targeted Arkansas Counties to stimulate or support coalitions to develop/implement locally designed programs to reduce unwed teenage pregnancy. Targeted counties were chosen from those with the highest teen pregnancy rates in the state with the goals to reduce teen pregnancy among adolescents through implementation of at least one "Programs that Work" curricula. The "Programs That Work" were eight different curricula possessing the strongest evidence of effectiveness in reducing the sexual risk-taking behavior of teens when the curricula were implemented with fidelity. In SFY 2009, four county coalitions were awarded Unwed Birth Prevention Funds ($32,000 each) in addition to one evaluation/technical assistance grantee ($30,000). The four counties were Jefferson, Phillips, Washington, and Pulaski.

During SFY 2009, the Unwed Birth Prevention Program served a total of over 7,400 youth: 1,021 through family planning services, 6,292 through "Programs that Work" curricula presentations, and 103 through behavior modification training. In addition, the Centers for Youth and Families in central Arkansas served a total of 62 minority mothers through their Pregnancy Prevention of Second Order Births program. The goal of this program was to empower young mothers in the Little Rock metro area to delay another pregnancy until they were better prepared. Participants received assistance in navigating the health care system and in providing a healthy, nurturing environment for their child(ren). Enrolled participants were also trained to develop personal, educational, and vocational skills for a more productive future. Reproductive health education, transportation to reproductive health clinics, and GED classes were also offered.

Also in SFY 2009, ADH utilized federal funds to help support abstinence education program activities. In SFY 2009, six community-based organizations impacting five counties were awarded federal funds totaling more than $136,000, to which approximately $125,000 in matching funds were contributed by the subgrantees themselves. A total of 3,885 young people aged 12-29 received abstinence-only education in accordance with federal guidelines. Although the majority of programs employed in-class abstinence curricula, other approaches were also employed, including rallies, A-teams, mentoring, after-school curricula, and other activities designed to promote abstinence.

Unfortunately, lack of state funds forced discontinuation of Unwed Birth Prevention projects on June 30, 2009. Federal funding for Abstinence Education was discontinued on the same date. In the absence of both federal and state funds to support it, the Arkansas abstinence-only program was discontinued at that time.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Title X (Family Planning) program served 20,401 males and females under 20 years old through provision of contraceptive services and supplies and health information			X	
2. The Center for Local Public Health provided outreach to teens and vulnerable populations		X		
3. Women's Health Section (Reproductive Health) provided health education through community presentations, health fairs, billboards, and radio and print media opportunities		X		

4. The Unwed Birth Prevention Program served 7,400 youth in 4 counties using educational curricula, family planning services, and behavior modification		X		
5. Abstinence-only education was provided to 3,885 young people in 5 counties using classroom curricula and other approaches		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Teen Pregnancy Prevention funds appropriated under the Consolidated Appropriations Act, 2010 (Public Law 111-117) are being carefully studied to determine how they can best be utilized within the state. Discussions with internal and external stakeholders are proceeding, and a letter of intent to apply for such funds has been submitted. Beyond this, similar funds authorized under health care reform in 2010 (Section 2953, the Personal Responsibility Education Program) are also being eyed. These acts both require use of evidence-based curricula/interventions, such as well-studied "abstinence-plus" programs.

Federal funding for abstinence-only education was also reinstated under health care reform (Section 2954). However, a decision regarding whether to apply for such funding has not yet been made by ADH.

ADH, Women's Health, provides funding and technical assistance to support the Home Town Health Initiatives (HHI). The HHI's activities include outreach to teens and hard to reach populations. This year the HHI is providing "National Teen Pregnancy Prevention" assistance and promotional materials to the LHU's. The Family Planning program has been provided Title X funds to provide outreach efforts to increase family planning users, specifically teens and low income people. The ADH Family Planning program continues to expand access and deliver free or low cost family planning clinical services, contraceptives, counseling/education and referrals.

c. Plan for the Coming Year

Despite the loss of Unwed Births state funds last year, several county coalitions have plans to continue teen pregnancy prevention efforts supported by other funding sources offered through their respective organizations.

Activities at the state level will proceed based on how much funding is received under the above-mentioned new federal teen pregnancy prevention initiatives. Teen pregnancy prevention activities (including abstinence-only and abstinence-plus curricula, and family planning) may again be contracted to community-based organizations possessing the greatest potential for high impact. However, important decisions regarding such activities are still pending.

The ADH Family Planning Program will continue to expand efforts in outreach to teens and vulnerable populations through the local health units. Women's Health and the Center for Local Public Health will continue to mail out annual appointment reminders to women in need of their annual appointments. Title X subgrantees, Wilbur Mills Substance Abuse Center in Searcy, AR and Ouachita Children's Center in Hot Springs, AR will continue to receive funding to support their efforts with high risk teens and other populations. Women's Health will continue to monitor and evaluate the efforts and accessibility of the family planning and maternity programs.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	30	16	18	19	18
Annual Indicator	15.0	15.0	15.0	17.0	20.2
Numerator	1071	656	197	206	132
Denominator	7138	4376	1312	1214	654
Data Source				Oral Health Branch, ADH	Oral Health Branch
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	21	22	23	24	25

Notes - 2009
A statewide dental screening survey was not conducted in 2008. Results are limited to dental screenings done by request of a local agency or organization.

A state-wide, county specific oral health needs assessment is being conducted in 2010. The survey, using contract dental hygienists in every part of the state, intends to screen as many as 9,000 third-grade students in the Spring of 2010.

Notes - 2008
A statewide dental screening survey was not conducted in 2008. Results are limited to dental screenings done by request of a local agency or organization.

Notes - 2007
A statewide dental screening survey was not conducted in 2007. Results are limited to dental screenings done by request of a local agency or organization.

a. Last Year's Accomplishments
Many programs of the Office of Oral Health (OOH) are funded by the Centers for Disease Control and Prevention (CDC) to augment the state oral health program. With the State Oral Disease Prevention Cooperative Agreement funding of $525,688, the OOH is building infrastructure and capacity within the State Oral Health program, supporting the Arkansas Oral Health Coalition, Inc. and expanding or creating effective programs to improve oral health outcomes and reduce disparities.

CDC grant funding has provided for additional staff, including the recent addition of a state sealant coordinator. The grant also provided funds to better assess oral health in Arkansas, to design new programs on dental sealants, tobacco cessation and prevention, and family violence prevention. The Office of Oral Health, working with various community leaders, has increased community water fluoridation in Arkansas to 65% of those people on water systems.

Working alongside the Arkansas Oral Health Coalition, OOH continued to support dental sealant programs in the state. The "Seal the State in 2008" project, funded through the Daughters of

Charity Foundation, ended in early 2009. Through this project, dental sealant awareness programs occurred in all 75 counties along with direct services for 2,000 at-risk children. Seal the State has grown into a cooperative initiative with Arkansas Children's Hospital that intends to provide dental sealants to children in as many as 32 school districts in 2010.

Together with comprehensive dental care provided by contract dentists, dental hygiene students from UAMS rotated through a school-based weekly clinic in Little Rock that OOH and partners formed, providing dental sealants to more than 500 children. In western Arkansas, a project in collaboration with Health Connections and UAMS Dental Hygiene Program provided dental sealants to almost 300 students.

Other initiatives include numerous presentations on family violence prevention presented to various health care professionals, Head Start agencies and lay audiences. Also, the successful Spit Tobacco Prevention Night with the Arkansas Travelers minor league professional baseball team -- based on the slogan, "Spit Tobacco: Chew, Dip and Die," is now in its ninth year and OOH has added a similar event at the Arkansas Naturals ball field in Northwest Arkansas. Head Start dental exams are performed when requested by Head Start staff.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A state dental sealant coordinator was hired to help design and implement statewide sealant programs				X
2. The proportion of Arkansans on public water systems whose water is fluoridated increased to 65%			X	
3. The "Seal the State" program provided dental sealants to over 2,000 at-risk children			X	
4. Seal the State also provided dental sealant awareness programs in all 75 counties in the state		X		
5. A collaboration among the Office of Oral Health, the UAMS Dental Hygiene program, and other partners led to sealant provision for almost 800 additional students in central and western Arkansas			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OOH continues to assess oral health across Arkansas, including open mouth surveys for children, adults, and the elderly. A state-wide, county-specific oral health needs assessment is currently underway to provide 5-year needs assessment to support the MCH Block Grant. The survey, using contract dental hygienists in every part of the state, intends to screen as many as 9,000 third-grade students in the spring of 2010.

Oral health workforce initiatives include funding dental recruitment efforts by Delta Dental of Arkansas, providing Grants-in-Aid to new dentists practicing in underserved areas, promoting dental careers in minority and rural populations, promoting language translation services in dental offices, increasing awareness on family violence prevention and providing in-school instruction in dental careers and oral health.

The CDC grant supports the "Governor's Oral Health Summit," now in its ninth year. The grant

also provides additional support for improving the community water fluoridation program in Arkansas. The grant funds educational opportunities to further the acceptance of fluoridation among policy makers, health care professionals, civic leaders, water plant personnel, and citizens, all based on the slogan, "Got Teeth? Get Fluoride!"

The Health Connections Section has developed its ConnectCare contract with Medicaid to establish more positions for the ConnectCare telephone helpline to link Medicaid recipients to dentists throughout the state.

c. Plan for the Coming Year
The Seal the State initiative, now in cooperation with Arkansas Children's Hospital, will target children in all Coordinated School Health schools across Arkansas with the goal of providing free dental sealants to all appropriate school children in Arkansas.

Expansion of community water fluoridation continues to be a major focus for the OOH.

Tobacco prevention, injury prevention and family violence prevention are all focus areas for educating healthcare professionals and lay audiences.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	4.2	6	6	3.9
Annual Indicator	5.7	7.5	5.7	3.9	3.3
Numerator	32	43	33	23	19
Denominator	557472	569943	579442	583073	583073
Data Source				2008 Death Certificates	2009 Death Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3.2	3.1	3	2.8	2.7

Notes - 2009
2008 population estimate 0-14 years was used to calculate 2009 rate.

The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

Notes - 2008
2007 population estimate 0-14 years was used to calculate 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

Notes - 2007
2007 death data are provisional.

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

a. Last Year's Accomplishments
Act 180, passed during the 2009 Arkansas Legislative session, provided for creation of a statewide trauma system, a major advance for Arkansas. Once fully implemented, the system will reduce response time for EMS services to transport injury victims to appropriately staffed and equipped medical facilities. A Level I trauma center will be established at UAMS, in Little Rock. ADH was part of a large coalition involved in supporting the act, and is now the lead agency for implementation.

Other important state policies passed during the last year, which went into effect 7/1/09, included a change in the seat belt law from secondary to primary enforcement. Drivers may now be stopped by law enforcement simply for not wearing a seat belt. Also very relevant to youth, a graduated driver's licensing act was passed which imposes various restrictions on novice drivers between 16 and 18 years old. Drivers less than 21 years old are now forbidden to talk on a cell phone in Arkansas as a result of another new law, and texting while driving was banned for drivers of all ages. All of these measures should have favorable impact on Arkansas's motor vehicle fatality rates, which have traditionally been much higher than national rates.

Subsequent to passage of the above laws, the ADH Injury Prevention and Control (IP&C) Branch collaborated with Arkansas Children's Hospital, UAMS, ADH Hometown Health Improvement, key school districts, and numerous other community partners to implement a pilot study, "Parents Are The Key." This pilot was implemented in two different areas of the state to assess the effectiveness of an online educational program aimed at parents of young drivers. The web-based program contained information related to the new Arkansas laws. Several useful findings from the pilot will help guide future educational programs.

Much credit both for advocacy for the above laws and for educating the public goes to the Arkansas Children's Hospital Injury Prevention Center, directed by Mary Aitken, MD, MPH. In the past year, the Center continued intensive work on several priorities related to motor vehicle injuries. The Child Passenger Safety Program, using NHTSA funds flowing through the state Highway Safety Office, continued to offer trainings around the state to certify interested community members as child passenger technicians. A number of safety seat checkup events were also held in various communities, sometimes in cooperation with county Hometown Health

Improvement staff. Other community education presentations and materials were also provided through the program. For older youth, the Drive Smart Challenge was sponsored for high schools in the Little Rock area, involving student-led educational campaigns and observational surveys of cell phone and seat belt use over a four-week period in the spring. Although not traffic-related, the ACH Injury Prevention Center also continued efforts to reduce ATV injuries through prioritizing 4 issues: 1) appropriate size of the ATV for the rider; 2) helmet use; 3) rider training; and 4) single riders. Educational materials were produced that could be co-branded with other stakeholders' logos, and a presentation on ATV safety was made at a Regional meeting.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Act 180 of 2009 designated 20 million dollars for creation of a statewide trauma system. Work was begun and a Trauma Section within ADH is planned.				X
2. New laws went into effect July 1, 2009 which provided for graduated driver's licensing of teens 16-18 years old, and which banned cell phone use by young drivers				X
3. A law providing for primary enforcement of seat belt use went into effect July 1, 2009.				X
4. The Injury Prevention and Control Branch participated in a pilot project to assess effectiveness of an online educational module ("Parents Are The Key") in two parts of the state.				X
5. The Arkansas Children's Hospital Injury Prevention Center offered child passenger technician certification trainings around the state.				X
6. The Arkansas Children's Hospital Injury Prevention Center provided safety seat checkup events at multiple sites in the state.			X	
7. The Arkansas Children's Hospital Injury Prevention Center stressed prevention of all-terrain vehicle injuries through public education			X	
8. Key positions (director, epidemiologist) were filled in the Injury Prevention and Control Branch				X
9.				
10.				

b. Current Activities

A Branch Chief for Injury Prevention and Control at ADH has recently been hired, and the branch infrastructure is being developed. The IP&C Branch continues collaborative activities with Hometown Health, Arkansas Safe Kids, and the Arkansas Children's Hospital (ACH) Injury Prevention Center around child passenger safety. A quarterly newsletter is being developed by the new IP&C epidemiologist in conjunction with the ACH group; the first issue was released in May 2010 and contained information on prevention of common summertime childhood injuries.

Work on the state trauma system is proceeding briskly, with the ADH Emergency Medical Services Branch taking a strong role in coordination. Personnel have been hired and critical stakeholders from outside ADH are acutely engaged. The enabling legislation for the system also provided funds for some primary prevention activities, and planning for use of those funds is proceeding with major input from the new IP&C Branch Chief.

The ACH Injury Prevention Center continues work on many fronts, as described under Section a. Research is also a strong component of the Center's activities, with several projects currently

underway. One example is the "Batter Up! Strike Out Child Passenger Injury" project, which aims to assess whether an intervention linked to t-ball programs in rural communities will increase use of appropriate booster seats among 4-7 year olds. This project is funded by CDC and is conducted in three other states as well.

c. Plan for the Coming Year

As noted, development of the Injury Prevention and Control Branch (IP&C) within ADH will proceed. In addition to an epidemiologist and administrative assistant, recruitment for other positions within the Branch is proceeding. Creation of a Trauma Section to oversee trauma system development and maintenance is planned, and recruitment of a Trauma Section Chief is underway. Recruitment of trauma system nurse consultants is also beginning. The primary prevention component of the trauma system is expected to be carried out through public health educators who will be housed in the five regions of the state. These positions are being advertised now, and it is expected they will be filled in the next fiscal year.

As before, the IP&C will continue to work with communities, schools, faith-based groups, and various standing coalitions to provide injury-related data and technical assistance. Collaborative activities with the ACH Injury Prevention Center, such as on the quarterly newsletter and on age-group specific child passenger safety initiatives, will also proceed.

The ACH Injury Prevention Center continues to grow rapidly. The Center intends to further a multitude of child passenger related projects using funding from a variety of state and national sources. The Center will also continue to serve as a resource center and as a strong advocate for appropriate injury prevention policy. ATV injury prevention activities are also proceeding, including a webinar being planned in conjunction with Children's Safety Network.

ADH Family Health will continue to monitor implementation of the newer motor-vehicle injury related laws and partner as needed with EMS, ACH, Hometown Health Improvement and the IP&C Branch in all aspects of injury prevention particularly as related to motor vehicle crash deaths and injuries. Family Health will continue to closely follow health statistics related to children injured or killed in motor vehicle crashes to help gauge the impact of these important policies in Arkansas.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		14	25	26	27
Annual Indicator	13.6	24.6	23.4	26.4	26.6
Numerator	3425	8960	8913	10147	10016
Denominator	25095	36481	38017	38428	37653
Data Source				2007 PRAMS survey	2008 PRAMS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28	28	29	30	31

Notes - 2009
2009 data are from the 2008 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2008.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2008 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

Notes - 2008
2008 data are from the 2007 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2007.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2007 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

Notes - 2007
2007 source is 2006 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2006.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2006 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

a. Last Year's Accomplishments
During the year, the fifth annual breastfeeding training, Breastfeeding: A Course for Health Professionals was offered by the WIC program for continuing education hours for nurses, dietitians, home economists and breastfeeding counselors as well as health professionals in the community. This course is jointly sponsored by WIC, Arkansas Children's Hospital and the University of Arkansas for Medical Sciences (UAMS).

A competency based breastfeeding self-study training module for WIC professionals and support staff was also offered through A-Train, the agency's web-based staff training resource. Continuing education hours were approved for professional staff.

USDA Southwest Region states continued the Loving Support breastfeeding education bag collaborative project. Arkansas distributed 21,000 education bags in 85 clinics as part of the required nutrition education-breastfeeding promotion to pregnant women at the initial WIC certification. Funding has been received to continue the bag project for the next fiscal year in every county of the state.

A toll-free Breastfeeding Helpline was operational. Each Health Unit has an onsite breastfeeding

contact person to coordinate the local breastfeeding support and promotion plan. Local Health Unit staff maintained a clinic environment that endorsed breastfeeding. For example, there is a requirement that no formula displays or items displaying formulas or company names can be displayed. Areas are designated for moms who want or need to breastfeed. Each Local Health Unit provided at least one breastfeeding promotion project for the year, which included health fairs, lobby or clinic displays, and participation in World Breastfeeding Week displays.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The fifth annual breastfeeding training for healthcare providers was held, jointly sponsored by WIC, UAMS, and Arkansas Children's Hospital.				X
2. A competency-based breastfeeding self-study module for WIC staff was provided through the agency's web-based training center.				X
3. The Loving Support breastfeeding "education bag" collaboration succeeded in delivering 21,000 education bags in 85 ADH clinics statewide. to pregnant women at their initial WIC certification visit		X		
4. The WIC program maintained a toll-free breastfeeding helpline.		X		
5. ADH clinic environments endorsed and promoted breastfeeding as the optimal method of infant nutrition through posters, designated breastfeeding rooms, and at least one promotion project per unit each year		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The above activities continue.

A monthly breastfeeding "Quick Notes" newsletter is sent out to all WIC staff through each Local Health Unit breastfeeding contact

The USDA evidence based training curriculum, "Using Loving Support To Grow and Glow in WIC: Breastfeeding Training for Local WIC Staff", is being conducted in 13 locations across the health department regions during months of March through May 2010. This competency-based training program focuses on a skills-building, interactive approach to assist staff in increasing confidence and skills in promoting and supporting WIC participants with breastfeeding. The training is designed to complement the messages from the new WIC food packages that were implemented in October 2009.

A media breastfeeding promotion campaign will be implemented during the month of August to complement World Breastfeeding Activities. The promotion will feature radio spots for the Texas WIC breastfeeding campaign;"Breastmilk: Every Ounce Counts" across the state. A promotional Lullably CD designed as part the "Every Ounce Counts" promotional campaign will be distributed to WIC pregnant women from WIC clinics.

Review of national data suggests breastfeeding peer counselors as a resource to mothers make significant contributions to breastfeeding rates. The ADH WIC program continues to seek funds to expand the peer counselors' effort. An additional six peer counselors positions were approved and will be filled this fiscal year.

c. Plan for the Coming Year
The above "Grow and Glow" breastfeeding training curriculum will continue to be offered to WIC staff in face to face regional trainings and/or through an online format that is currently under development.

The "Loving Support Breastfeeding Education Bag" project for pregnant women will continue to be offered statewide.

The breastfeeding peer counselor program will continue to be evaluated for expansion options to more counties in the state.

Breastfeeding: A Course for Health Professionals will be re-evaluated in the coming year to deliver a format of updates that more effectively targets the needs of health professionals and hospitals in the state. The course is co-sponsored by the Arkansas Department of Health-WIC, Arkansas Children's Hospital and the University of Arkansas for the Medical Sciences, College of Medicine.

Capturing data on breast-feeding activity at 6 months of the baby's age can be done only for WIC patients. However, PRAMS data surveys women in the 2nd to 4th month after a delivery. That data has provided a more population-wide view of breastfeeding practices, a picture that is quite different from the behavioral choices of women on WIC. We prefer to present data on breastfeeding progress taken from PRAMS data, which means the definition of the measure would have to change from 6 months to "at the time of the PRAMS survey."

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	97	97.9	98.3	98.4	99
Annual Indicator	97.8	98.2	98.2	99.0	98.9
Numerator	36789	37866	38978	38468	37457
Denominator	37610	38573	39682	38865	37883
Data Source				ADH Infant Hearing Program	ADH Infant Hearing Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	99	99	99	99	99

Notes - 2009
The denominator is the number of forms received from birthing hospitals (37,883). The numerator is the number of infants (reported on forms) that received hearing screens (37,457) before hospital discharge.

Notes - 2008
Denominator is number of forms received from hospitals (38,865). Numerator is number of infants (reported on forms) that received hearing screens (38,468).

Notes - 2007
Denominator is number of forms received from hospitals (39,682). Numerator is number of infants (reported on forms) that received hearing screens (38,978).

a. Last Year's Accomplishments
The Infant Hearing Program (IHP) collaborated with the University of Arkansas at Little Rock, Institute of Government, to develop and perform a Needs Assessment to identify challenges in the initial screening and follow-up testing of infants' hearing, as well as recommendations for program improvement. Themes and recommendations from the survey included: 1) Parents, physicians, and the birthing hospitals must share the responsibility for follow-up, 2) Care providers and parents should examine and improve communications to increase the likelihood that an infant will be returned for retesting, 3) Education of parents must be emphasized, 4) Better reporting by hospitals and information-sharing by ADH, 5) ADH should work with care providers to improve services, 6) Hearing testing equipment must be available and in functioning order, and 7) Further research on roles of family care physicians, audiologists, ENTs, and parents.

In addition, the IHP worked with the Information Network of Arkansas (INA) to design a dot com website in English and Spanish with specific section information for stakeholders involved with newborn/infant hearing screenings. The website has section devoted specifically to parents, physicians, and hospital personnel with printable forms and numerous links.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Universal hearing screening in the hospital of birth is mandated by state law. Only hospitals delivering less than 50 babies per year are exempted. Lay midwives are also required to arrange for hearing screens.			X	
2. Birth hospitals were provided with technical assistance in physiologic testing and data submission.				X
3. A database was kept at ADH, populated with birth certificates and matched for each baby. Monthly data reports were sent to the reporting hospitals.				X
4. Abnormal reports were identified and physicians and parents were notified of the need for follow-up testing. Telephone calls with both physicians and parents were made when necessary to assure this follow-up.			X	
5. Confirmatory audiologists' testing results were reported to the database.			X	
6. The program was guided by an advisory council of experts.				X

7. The program worked with Early Intervention (Part C) to assure needed services for children with diagnosed hearing loss.				X
8. A needs assessment was developed and conducted by an outside entity to identify challenges in the initial screening and follow-up testing of failed hearing screens.				X
9. The program began working with VR/Health Statistics to link data input with the new Electronic Birth Certificate. The software vendor has been chosen and functional requirements for design of the linkage completed.				X
10.				

b. Current Activities

The Infant Hearing Program (IHP) and the Vital Records/Health Statistics Department at the Arkansas Department of Health are working on an electronic web-based reporting system for hearing screening and diagnostic information which will be linked with the birth certificate data. Currently, the project is in the design phase with an expected go-live date of 4/2011. Other projects of the IHP include a contract with a pediatric audiologist to provide hands-on training to birthing hospitals that have a less than desired refer (failed hearing screens) rate. The program also worked with the University of Arkansas at Little Rock, Institute of Government, Survey Research Center to develop a physician survey to better understand the attitudes, knowledge of Early Hearing Detection and Intervention (EHDI) goals, and practices of hearing screening and referral procedures in pediatrician offices.

c. Plan for the Coming Year

The Electronic Infant Hearing Module and the Electronic Birth Certificate link will continue as a major focus for the coming year. A tentative schedule for the Electronic Vital Records Event (including the Infant Hearing Module) estimates April 2011 as the completion date. The IHP will be able to collect additional demographic data and other vital data information that is unavailable to the program currently. The revision to an electronic format should allow the data from hospitals to be received by the state office in a timelier manner than the program's current paper-based system.

A Memorandum of Agreement (MOA) with Part C will be formalized for data exchange of infants/children referred to Part C for Early Intervention Services. The MOA will allow the IHP to receive individualized information for infants/children regarding eligibility, enrollment, and types of services received. The Program also has plans for a collaborative pilot project with the University of Arkansas Medical Sciences, Office of Health Related Professions, Department of Audiology and Speech Pathology. The pilot project will implement five non-traditional hearing screening sites in selected areas of the state, as well as one site with a particular focus on families whose primary language is Spanish. The pilot project sites will be in underserved areas and will be at no charge to parents. The project will offer parents an option for obtaining hearing screening in a less threatening environment, offer a pediatric provider in a rural state of under-served areas, decrease distance travel for many parents, provide a no-charge hearing screen, and offer hands-on training for graduate students of the University's Audiology Program.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	7	7	10.8	10.8	6

Annual Indicator	10.7	9.3	9.3	6.2	9.2
Numerator	72000	65000	65167	44425	65157
Denominator	673000	699000	698812	719784	710422
Data Source				US Census Bureau	US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	8.5	7	6	5.5	5

Notes - 2009
2009 indicator populated with 2008 data.

Data source: U.S. Census Breau, Current Population Survey, Annual Social and Economic Supplement, 2009

Notes - 2008
2008 indicator populated with 2007 data.
Data source: U.S. Census Breau, Current Population Survey, Annual Social and Economic Supplement, 2008

Notes - 2007
2007 indicator populated with 2006 data.
Data source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007

a. Last Year's Accomplishments
Arkansas Act 180, passed into law during the 2009 legislative session, established a new tax on tobacco products to fund a number of health initiatives, including an expansion of Medicaid (ARKids B) eligibility to 250% of the federal poverty level. It was projected that at least 8,000 children would benefit directly from the expansion, while another 12,000 additional children already eligible for AR Kids under the existing criteria (200% FPL) would also become enrolled. Unfortunately, a shortfall in state General Revenue forced the Medicaid program to delay implementation of this measure, and eligibility limits remain at 200% FPL. Nonetheless, a total of 30,000 children were added to Medicaid rolls between July 2008 and December 2009, no doubt a a reflection of the depressed economy during that period.

Meanwhile, the Arkansas Finish Line Coalition, composed of a large number of health, social service, and education organizations, continued a campaign to promote a variety of measures related to health coverage for children. These included expansion of Medicaid to more children (300% FPL), creation of electronic enrollment and re-enrollment systems, continuous coverage for children served under traditional Medicaid (ARKids A), and creation of a buy-in option for families just over the income limit. The Coalition continued to be staffed by Arkansas Advocates for Children and Families.

The Health Connections Section (HCS) Health Educator staff, funded through the Medicaid ConnectCare contract, provided Health Education/Promotion/Outreach, working collaboratively

with schools, Head Start, Hometown Health, local health units and other local organizations. In an effort to encourage Medicaid enrollment, particular emphasis was placed in areas of the State with a high Medicaid-eligible population. The Health Educator staff continued establishing their role as a resource to support school based Human Service workers. These staff produced a variety of newsletters, brochures, and other written materials addressing such concerns as prenatal care, WIC, immunizations, newborn screening, tobacco use and obesity. Health Education personnel included a bilingual (Spanish/English) health promotion/outreach specialist.

Other HCS staff, also funded through the Medicaid ConnectCare contract, operated the ConnectCare telephone Helpline from 6 a.m. Monday through 10 p.m. Friday to assist Medicaid/ARKids First recipients with locating and assigning primary care physicians and dentists and to provide resource information. Helpline staff included a bilingual operator to help Spanish-speaking families identify medical and dental providers. Beginning July 1, 2009, the program began linking adult Medicaid participants with dental care providers.

The HCS additionally served as a resource for general health information. An Arkansas Health information telephone helpline operational 8 a.m. to 4:30 p.m. Monday through Friday provided callers with information regarding prenatal care (Campaign for Healthy Babies), smoking cessation (Clean Indoor Air), WIC, immunizations, and numerous other requests for health resource information and accessing services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Act 180 of 2009 provided funding to allow expansion of the Medicaid (ARKids B) income eligibility limit to 250% FPL.				X
2. The Arkansas Finish Line Coalition continued to press its goals of expanded Medicaid coverage of children, creation of improved enrollment systems, and creation of a buy-in option for families over the income limit.				X
3. Health Connections Section health education, promotion and outreach staff worked with schools, Head Starts, LHU's and HHI to encourage enrollment in Medicaid in selected areas of the state.		X		
4. Under contract with the state Medicaid agency, Health Connections Section helpline operators assigned Primary Care Physicians to new and established Medicaid beneficiaries.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The state Medicaid agency is in the process of reviewing recommendations from stakeholders on how best to deal with the current shortfall in state funds without having to cut coverage of key services. Although no reduction in eligibility is planned, there may be additional administrative conditions imposed such as prior authorization for certain prescriptions and procedures. A clinical utilization review panel for Medicaid will probably also be established. However, final decisions are still pending.

The Arkansas Finish Line Coalition continues to meet and work toward its goals. The Coalition has weighed in on the current Medicaid crisis with its own recommendations and is planning to

pursue other avenues of public awareness. These include letters, personal stories, and op-ed pieces for submission to local newspapers, and a series of regional forums to discuss national and region-specific health care coverage issues.

HCS activities outlined above continue this year.

Recently passed national health care reform legislation is being studied. However, since many provisions do not go into effect immediately, it will probably be several years before the true impact is known.

c. Plan for the Coming Year

ADH will continue to partner with the state Medicaid agency, Arkansas Advocates for Children and Families, and all the other Finish Line organizations to move toward the goal of coverage for 100% of children. Although state budgetary concerns have created a brief "hiccup," the passage of national health care reform and continued enthusiasm within the state suggest that this goal is still realistic.

The Health Connections Section will continue to build relationships with WIC, immunizations, tobacco, and dental health to assure that during contact to set up a PCP assignment, that contact is used to provide other key health care information related to prenatal care, smoking cessation, dental care, well child care and other preventive health issues. HCS will also continue to assist child and adult Medicaid recipients with dental appointments and coordinated dental care. In the coming year, HCS will pilot a process of on-site PCP assignments at health fairs and kindergarten "roundups." A wireless connection to ADH software will enable remote verification of a beneficiary's status and assignment of a PCP on the spot at such events.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12.9	12.9	12.9	15.5
Annual Indicator	12.7	12.6	15.8	15.9	16.8
Numerator	3893	4159	5590	6136	7369
Denominator	30655	33008	35378	38591	43801
Data Source				2008 WIC-PEDNSS	2008 WIC-PEDNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16	14.5	14.5	14	13.5

Notes - 2009

The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2008
The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2007
The majority of children receiving WIC services are preschool age children.

a. Last Year's Accomplishments
As in the past, children participating in WIC were prescribed food packages based upon age, but tailored to fit individual needs. All participants received nutrition education designed to address immediate concerns and improve overall health. In addition, one-on-one nutrition counseling with a registered dietician regarding specific nutrition-related health problems continued to be available in local health units.

WIC also administered the Farmers' Market Nutrition Program (FMNP), the mission of which is to encourage the consumption of fresh fruits and vegetables and encourage the development of farmers' markets. Women and children residing in counties with farmers' markets were eligible to receive food coupons which could be redeemed for fresh produce from June through October, 2009.

The implementation of the new WIC MIS, Successful Partners in Reaching Innovative Technology (SPIRIT), was complete at the end of March 2009. This project was funded by the USDA Food and Nutrition Service. SPIRIT is a State Agency Model (SAM) designed to reduce paperwork, improve program integrity and security, improve data accuracy, state efficiency and productivity and reduce system support and maintenance issues. Clinic WIC staff were given SPIRIT training prior to their county roll out.

Value Enhanced Nutrition Assessment (VENA) was implemented in conjunction with SPIRIT rollout. VENA takes a positive approach based on desired health outcomes rather than deficiencies. VENA's emphasis is to improve the current assessment practices by promoting a positive, client-centered approach to obtain information that is used to
-provide individualized nutrition education
-determine nutrition eligibility
-tailor food package
-make appropriate referrals

The Interim Food Package rule was implemented September 28, 2009. This was the first major change to the supplemental foods offered through the program in 30 years. Major changes include the provision of fresh and frozen fruits and vegetables, whole grain foods (such as whole grain bread, tortillas, and brown rice), baby foods and soy beverages. The new food packages contribute to an overall diet that is consistent with established dietary recommendations for infants and children less than 2 years of age, including encouragement of and support for breastfeeding. The packages also contribute to an overall dietary pattern recommended for individuals 2 years of age and older.

All LHU WIC unit staff received training related to the implementation of the Interim Food Package Rule by September, 2009. "WIC Food Packages: Making the Change Work" was an interactive approach to assisting WIC Competent Professional Authorities (CPAs) in assessing participants to prescribe appropriate food packages and nutrition education. Clerical staff received training regarding their roles in implementation of the new food packages.

WIC participants received newsletters at each WIC pick up with information about the new food packages.

All WIC vendors were given intensive training on the new food items that would be purchased with WIC checks.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC participating children received nutrition education and individualized nutrition counseling, as indicated.		X		
2. WIC administered the Farmers' Market Nutrition Program that encouraged consumption of fresh fruits and vegetables.			X	
3. The new WIC information management system (SPIRIT) was implemented statewide.				X
4. Value Enhanced Nutrition Assessment was implemented.				X
5. The new food packages containing healthier food choices were implemented in September 2009.		X		
6. Training of local health unit WIC staff in the new food packages was completed by September 2009.				X
7. Parents of WIC participants received newsletters concerning the food package changes at every scheduled visit.		X		
8.				
9.				
10.				

b. Current Activities

1. WIC continues the activities described above.

2. Revision of WIC policy and procedures to comply with the new MIS, VENA and the new food package rules has been completed.

3. Training is on-going for new staff on SPIRIT and as additional needs are identified.

4. The transition to WIC Electronic Benefit Transmission (EBT) is in the planning stages. Funds have been awarded to conduct an EBT feasibility study.

c. Plan for the Coming Year

1. Continuation of current activities as described.

2. Continuing strategic planning for WIC Electronic Benefit Transmission (EBT) transition.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		18.4	20.9	20.7	18.5
Annual Indicator	18.5	20.9	19.4	18.8	24.0
Numerator	6339	7552	7326	7099	8866

Denominator	34339	36160	37683	37857	36987
Data Source				2007 PRAMS Survey	2008 PRAMS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	19.5	18.5	17.6	17.3	17

Notes - 2009
2009 data are from the 2008 PRAMS survey.

Notes - 2008
2008 data are from the 2007 PRAMS survey.

Notes - 2007
2007 data source is 2006 PRAMS survey.

a. Last Year's Accomplishments
The Arkansas Tobacco Quitline (ATQ) began operating in October 2008. It is funded through the Arkansas Department of Health, Tobacco Prevention and Cessation Program. The ATQ provides telephone based cessation services for tobacco users 16 years and older. Access to the ATQ is available by calling the toll free phone number, faxed referral and through the "stamp-out-smoking" website. The ADH Tobacco Cessation Program reported for 2008 that 15.3% of Arkansas mothers and pregnant women smoked (6,188/40,489 births). Woodruff County, at 33.8%, had the highest rate of smoking pregnant women and mothers. The ATQ provides a proactive program to assist these women (and any other tobacco users) who desire to quit tobacco. Within the ADH local health units, all maternity, family planning, WIC and STD clients are screened for tobacco use. The Women's Health and WIC programs include tobacco use questions in their history and counseling components with referral guidance for the nurses/clinicians/other staff to provide to the patient. ADH Nurse Practitioners utilize the UAMS ANGELS tobacco dependent/cessation guidelines for pregnant, postpartum and family planning patients. Programs provide written information in English and Spanish on the risks of smoking and information on cessation resources.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Arkansas Tobacco Quitline provided tobacco cessation services to women aged 16 years and older		X		
2. All Maternity, Family Planning, WIC, and STD clients seen in local health units were screened fro tobacco use and referred for services as appropriate			X	
3. ADH Women's Health Nurse Practitioners provided tobacco cessation guidance to pregnant and postpartum women and to Family Planning patients using ANGELS guidelines		X		
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

ADH local health unit staff must determine tobacco-use status of all patients, advise them to quit and refer those willing to quit to the Arkansas Tobacco Quitline (ATQ) by the faxed referral program. The ATQ is a free, proactive referral system that provides assistance to those over age 16 who are willing to quit tobacco within 30 days. Registrants can contact the ATQ seven days a week, 7am-2am. All pregnant women, those planning a pregnancy within 3 months, or those breastfeeding who are using tobacco are eligible for a special cessation program. ATQ takes a woman-centered approach, balancing the benefits of quitting for both the fetus and the woman. Quitline coaches are supportive and empathetic with pregnant tobacco users. In addition, Quitline coaches provide information about pharmacotherapy options specific to pregnant women. Women are encouraged to engage in meaningful discussion with their physician about the pros and cons of using pharmacotherapy to aid their cessation effort.

In addition to the telephone access line to the ATQ Quitline coaches, the ATQ Pregnancy Program includes up to 10 calls by the Quitline Coach with relapse sensitivity via phone or online tailored to the specific needs of each tobacco user with the first 5-6 calls made within 60-90 days of enrollment; one call within 30 days before the woman's due date; and at least 2 calls postpartum with content structured for pregnant smokers.

c. Plan for the Coming Year

Tobacco prevention and cessation education will continue to be provided in the ADH local health units and through the outreach efforts of the Tobacco Cessation Program. The Arkansas Tobacco Quitline will continue to provide assistance to tobacco users via phone and online. ATQ Pregnancy Program will continue to provide the specialized assistance program that includes structured content for pregnant smokers. ADH continues to provide PRAMS data to state health officials and policy makers.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.5	10	9	8	10
Annual Indicator	14.2	9.7	8.1	10.6	7.1
Numerator	28	19	16	21	14
Denominator	196748	196492	197560	197229	197229
Data Source				2008 Death Certificates	2009 Death Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7	7	7	6.5	6

Notes - 2009
2008 population estimate 15-19 years was used for 2009 rate.

The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

Notes - 2008
2007 population estimate 15-19 years was used for 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

Notes - 2007
2007 death data are provisional.

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

a. Last Year's Accomplishments
The Arkansas Youth Suicide Prevention Task Force was established by Arkansas Act 1757 of 2005. The Task Force includes representatives from behavioral health, education, youth services, law enforcement, and others interested in the issue. Administrative support for the Task Force is housed within the Arkansas Department of Education (ADE), which facilitates quarterly meetings for the group.

In the past year, staff from ADE continued to provide training in the "Gatekeeper" model which originated in Maine. Five such trainings were held last year. The trainings not only teach school counselors, teachers, and administrators to recognize warning signs for suicidal behavior, but also equips attendees with tools needed to share this information with others. All trainees are provided with a Power Point presentation and are expected to present this 2-hour slide show to other staff when they return to their schools. In addition to school personnel, other attendees last year included police and local clergy.

The Task Force also provided 300,000 pocket-sized cards to public school students containing resources for acute help, such as crisis line numbers and examples of others that youth could turn to for assistance. These cards were distributed through the 15 Educational Cooperatives

around the state and were targeted to 6th-12th graders.

Working somewhat separately from the Youth Suicide Task Force, the Attorney General's Office also sponsored several activities. For example, they held an anti-suicide poster (artwork) contest for students in conjunction with the Jason Foundation at Pinnacle Pointe Hospital (a provider of behavioral health services for youth). The AG's Office also has a curriculum designed to discourage suicide which has been provided in some schools.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Arkansas Youth Suicide Prevention Task Force continued to meet quarterly, facilitated by the Arkansas Department of Education (ADE).				X
2. ADE staff conducted five "Gatekeeper" train-the trainer workshops for school and community personnel on warning signs of suicidal behavior.				X
3. The YSP Task Force distributed 300,000 pocket size cards to 6th-12th graders around the state listing resources for help.			X	
4. The State Attorney General's Office sponsored anti-suicide poster artwork competitions and made a suicide prevention curriculum available for schools			X	
5. A meeting of over 100 interested parties was held to catalyze support for broader anti-suicide activities and begin development of a state strategic plan				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Youth Suicide Prevention Task Force continues to meet quarterly.

In March 2010, a meeting attracting over 100 attendees was held at Camp Robinson in central Arkansas, which is home to an Army National Guard unit. The Arkansas Military Department, which oversees the Army and Air National Guard, has recently expressed a strong interest in collaborative effort toward suicide prevention due to an increased incidence among both active military service personnel and their family members. Many different disciplines and agencies were represented at this meeting, all of them there with the interest of expanding suicide prevention activity through formation of a broader coalition. The group agreed to work toward creation of a state strategic plan.

As part of its work, the group formed several committees to work on various aspects of the plan. Representatives of ADH's Injury Prevention and Control (IP&C) Branch attended the meeting and are members of the Funds/Resources committee. IP&C staff are compiling abstracts related to specific suicide prevention topics and sending them to other members who have access to relevant Requests for Proposals. Other information that has been shared by IP&C is YRBS data on topics such as alcohol use, peer pressure, depression, and suicidal ideation to help support any grant applications that may be submitted.

c. Plan for the Coming Year
The Task Force will provide at least four additional trainings in the Gatekeeper model later this year. In addition to continuing routine quarterly meetings, ADE key staff members are helping coordinate the process of developing a state strategic plan for youth suicide prevention. Committees have been formed and development of the plan should proceed over the next year. Family Health staff will monitor progress of plan development through key contacts in the Injury Prevention and Control Branch, and may participate directly in certain phases of the process.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	67	67	69	70	70
Annual Indicator	66.5	66.0	58.8	64.6	70.2
Numerator	451	479	448	451	465
Denominator	678	726	762	698	662
Data Source				2008 Birth Certificates	2009 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	71	71	72	72	73

Notes - 2009
2009 indicator represent data from Federal Fiscal year 2009.

Notes - 2008
2008 indicator represent data from Federal Fiscal year 2008.

Notes - 2007
2007 indicator represent data from Federal Fiscal year 2007.

a. Last Year's Accomplishments
The increased percentage of very small babies delivered at perinatal tertiary care centers in recent years is probably attributable in large part to activities carried out under the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) initiative. ANGELS represents a multi-pronged approach to perinatal care systems improvement through telemedicine, high risk pregnancy consultation, professional education, practice guideline development and dissemination, creative reimbursement processes through Medicaid, and more. The project is primarily a partnership between Medicaid and the UAMS Department of OB/GYN, but many other collaborators are involved including ADH, Arkansas Children's Hospital, local and regional hospitals, AHEC's, local physicians, and in-state and out-of state evaluators and researchers. Last year ANGELS expanded its network of participating hospitals, including more than 25 hospital nurseries. The project continued to hold teleconferences and videoconferences

with participating providers several times a week on both obstetrical and neonatal topics. Six new obstetrical guidelines for providers were added. One significant result of all these activities has been an increase in (appropriate) high-risk maternal transports to UAMS.

In 2009, ANGELS performed 2,095 telemedicine consultations; facilitated 704 high-risk maternal transports to the closest, most appropriate hospital; and accepted or made 118,527 obstetrical patient or physician support calls through the 24/7 RN-staffed ANGELS Call Center.

Under contract with UAMS, Women's Health Nurse practitioners consulted directly with Maternal-Fetal Medicine specialists on high-risk maternity patients followed in local health units, and referred many such women to the UAMS High Risk OB Clinic. In 2009, telemedicine sites were established in five local health units, allowing direct contact between high-risk patients and specialists without the need for travel.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The ANGELS initiative expanded its network of participating hospitals/nurseries				X
2. ANGELS provided 2,095 telemedicine consultations for high-risk OB patients	X			
3. ANGELS facilitated 704 high-risk maternal transports to the closest, most appropriate perinatal care facility		X		
4. The ANGELS Call Center made or accepted over 118,000 obstetrical patient or physician support phone calls		X		
5. Under contract with the UAMS OB/GYN Department, ADH Women's Health Nurse Practitioners consulted with Maternal-Fetal Medicine specialists and referred high-risk patients to UAMS				X
6. Telemedicine sites were established in five county health units to improve access of high-risk maternity patients to subspecialty care				X
7.				
8.				
9.				
10.				

b. Current Activities

Current ANGELS initiatives of high-risk pregnancy consultation for primary care providers, development and dissemination of evidence-based practice guidelines, telemedicine (27 sites around the state), the 24-hour call center, provider education, and research are ongoing. The program continues to offer individual patient consultation including use of real-time, interactive fetal ultrasound, and continues to coordinate high-risk maternal transports to appropriate perinatal care facilities within the state and region.

c. Plan for the Coming Year

ANGELS anticipates further development of its provider network and expansion of telemedicine, teleconferencing and videoconferencing activities. ADH has recently met with ANGELS leaders regarding the potential for Call Center resources to be made available to ADH maternity patients in the coming year. Such an arrangement would allow pregnant women followed in local health units access to medical expertise at night and on weekends. Earlier access to medical advice would likely facilitate timely transport to an appropriate level of perinatal care in certain dire situations.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81	81	81	82	82
Annual Indicator	78.8	77.3	76.4	76.4	76.1
Numerator	30827	31065	31602	31450	29881
Denominator	39101	40203	41380	41168	39261
Data Source				2008 Birth Certificates	2009 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82	82	82	82	82

Notes - 2009
2009 indicator represent data from Federal Fiscal Year 2000.

Notes - 2008
2008 indicator represent data from Federal Fiscal Year 2008.

Notes - 2007
2007 indicator represent data from Federal Fiscal Year 2007.

a. Last Year's Accomplishments
ADH continued to support the Happy Birthday Baby Book. Healthy Baby is a program of the Arkansas Department of Health that encourages all pregnant women to receive early and continuous prenatal care. A total of 12,047 books were provided to Arkansas's pregnant women, with an additional 88 out-of-state requests. The Happy Birthday Baby Book can be requested by phone, internet or prepaid postcard.

Established in 1991, the ADH Resources and Health Information Line is a statewide, confidential, toll free information system that operates Monday-Friday, 8:00am to 4:30pm. It is staffed with employees trained to provide callers with public health and referral resource information. An electronic intranet resource is available to local health units through the ADH Intranet.

The Health Connections Section, through a contract with Arkansas Medicaid, continued work to connect Arkansas Medicaid recipients to healthcare providers and health resources in their community. This activity is performed by helpline operators who staff a telephone toll free helpline. The helpline operators' primary function is to assign Medicaid and ARKids recipients to a primary care physician and provide dental case management. They also respond to Medicaid and ARKids recipient questions and concerns, giving information and offering guidance on accessing local health resources.

The Department of Health continued direct provision of maternity services. There has been an increased number of Medicaid prenatal providers which has reduced the demand for local health unit prenatal services in some areas. ADH now provides prenatal services in 54 Local Health Unit sites in 49 counties as compared to 61 sites in 55 counties in 2008. Local Health Units continued to work with their communities and providers to ensure pregnant women have access to prenatal care. Clients were screened for presumptive eligibility Medicaid; given information on, and referrals to, medical providers; and afforded access to other ADH services. The Local Health Units saw 4,357 pregnant women for their initial prenatal appointments in CY 2009, of which 2,241 (51.4%) were seen in their first trimester.

ADH continued to serve the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse or domestic violence seek the non-judgmental care of the local health unit. Local Health Units provided pregnancy testing for women who want to confirm their pregnancy or those seeking pregnancy.

The Perinatal Health Program oversees the Lay Midwife (LMW) Program. Currently, there are 30 Licensed Lay Midwives and 14 Lay Midwife Apprentices. The choice to use a lay midwife for home birth may provide a viable alternative to maternity care in Arkansas, particularly for low risk pregnant women. LHU's provide risk assessments and referrals, as needed, for the LMW clients.

ADH continued to support and participate in the UAMS ANGELS activities, incorporating their guidelines into ADH policies. Activities included co-management of prenatal patients with UAMS Maternal Fetal Medicine (MFM), patient referrals to ANGELS, Telemedicine referrals, and prenatal genetic screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. More than 12,000 Happy Birthday Baby Books were provided to pregnant women around the state		X		
2. The toll-free ADH Health Information Line provided resource and referral information to callers 5 days a week		X		
3. The Health Connections Section continued to link Medicaid beneficiaries, including pregnant women, with primary care physicians		X		
4. ADH provided direct prenatal services to over 4,300 women in 54 local health units	X			
5. ADH provided pregnancy testing in all 93 local health units	X			
6. The Women's Health Section Perinatal Program provided oversight and quality assurance activities for the 40+ lay midwives and apprentices in the state				X
7. Collaboration with the UAMS ANGELS program continued, including incorporation of ANGELS guidelines into ADH policy, patient referrals, telemedicine referrals, and genetic screening				X
8.				
9.				
10.				

b. Current Activities

ADH continues to provide maternity clinics in many local health units. Referrals to private providers are facilitated by the application process for presumptive eligibility in local health units

in each ADH Region.

ADH continues to support and provide staff for the Happy Birthday Baby Book, a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care.

ADH clinicians and public health nurses continue to utilize the UAMS High-Risk OB-GYN Nurse Liaison in referrals for high risk conditions of pregnancy. The UAMS Nurse Liaison facilitates telephone consultations and appointment scheduling as needed for LHU maternity patients.

The ADH Physician Specialist continues to utilize ANGELS and the ANGELS Guidelines in the policies and care of ADH maternity patients. ADH physicians continue to participate in the ANGELS teleconferences and provide direction regarding ADH policies.

The PRAMS Grant is used extensively for program planning and dissemination of information and data to public and private entities throughout Arkansas. ADH continues to support the MCH Epidemiologist position. This individual provides continued work on program evaluation, needs assessment and analysis of common perinatal health indicators.

c. Plan for the Coming Year

ADH will continue to provide support for the local health units' maternity clinics, as well as for collaborative activities surrounding the UAMS ANGELS program. ADH will continue to support the MCH Epidemiologist position. Support will continue for the Happy Birthday Baby Book. ADH physicians will continue to participate in the ANGELS teleconferences and provide direction regarding ADH policies. The Family Health Branch will continue utilization of the perinatal information obtained through PRAMS.

D. State Performance Measures

State Performance Measure 1: *The percent of Arkansas high school students who have engaged in sexual intercourse.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		55	55	55	54
Annual Indicator	54	54	54.9	54.9	53.6
Numerator					
Denominator					
Data Source				2007 YRBSS	2009 YRBSS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	53	52	51	50	

Notes - 2009

Data source: 2009 YRBSS, Centers for Disease Control and Prevention.

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Notes - 2008

Data source: 2007 YRBSS.

YRBSS is conducted in odd years. The 2007 survey results are reported for the 2008 indicator.

Notes - 2007

Data source is 2007 national Youth Risk Behavior Survey.

a. Last Year's Accomplishments
During State Fiscal Year 2009, ADH utilized federal funds to help support abstinence education program activities. In SFY2009, six community-based organizations impacting five counties were awarded federal funds totaling more than $136,000, to which approximately $125,000 in matching funds were contributed by the subgrantees themselves. A total of 3,885 young people aged 12-29 received abstinence-only education in accordance with federal guidelines. Although the majority of programs employed in-class abstinence curricula, other approaches were also utilized, including rallies, A-teams, mentoring, after-school curricula, and other activities designed to promote abstinence.

Also in SFY09, ADH and the Unwed Birth Comprehensive Strategies Committee funded a limited number of community-level Unwed Birth Prevention Programs through a competitive RFA process. Coalitions in four counties received funds to implement proven curricula for reduction of sexual risk-taking among teens. Many of the curricula employed in the sites featured an "abstinence-plus" strategy. Over 7,400 youth were served during SFY2009 through this program, most of whom participated in an approved educational curriculum; however, about 1,000 received family planning services.

Federal funding for Abstinence Education was discontinued June 30, 2009. In the absence of both federal and state funds to support this activity, the program was discontinued at that time. Unfortunately, lack of state funds also forced discontinuation of Unwed Birth Prevention projects at the same time.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Abstinence-only education was provided to 3,885 young people in 5 counties using classroom curricula and other approaches			X	
2. The Unwed Birth Prevention Program served 7,400 youth in 4 counties using educational curricula, family planning services, and behavior modification			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Federal funding for abstinence-only education was recently reinstated under the Patient Protection and Affordable Care Act of 2010 (Section 2954). However, a decision regarding whether to apply for such funding has not yet been made by ADH.

The Teen Pregnancy Prevention funds appropriated under the Consolidated Appropriations Act, 2010 (Public Law 111-117) are being carefully studied to determine how they can best be utilized within the state. Discussions with internal and external stakeholders are proceeding, and a letter of intent to apply for such funds has been submitted. Beyond this, similar funds authorized under health care reform in 2010 (Section 2953, the Personal Responsibility Education Program) are

also being eyed. These acts both require use of evidence-based curricula/interventions, such as well-studied "abstinence-plus" programs.

c. Plan for the Coming Year
Activities will proceed based on how much funding is received under the above new initiatives. Teen pregnancy prevention activities (including abstinence and abstinence-plus) activities may again be contracted to community-based organizations possessing the greatest potential for high impact. However, important decisions regarding such activities are still pending.

State Performance Measure 2: *The percentage of children through age 18 and below 200 percent of poverty enrolled in ARKids First child health insurance program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	85	35	35	79
Annual Indicator	85.6	91.2	76.4	76.9	83.5
Numerator	290170	295053	305720	301038	314641
Denominator	339000	323408	400372	391490	376788
Data Source				Arkansas Medicaid Program	Arkansas Medicaid Program
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	82	82	82	82	

Notes - 2009
Population below 200 percent of poverty data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009. 2009 population below 200 percent of poverty are from 2008.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

Notes - 2008
Population below 200 percent of poverty data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008. 2008 population below 200 percent of poverty are from 2007.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

Notes - 2007
2007 population below 200 percent of poverty are from 2006.
Population below 200 percent of poverty data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

a. Last Year's Accomplishments

The Health Connections Section (HCS), funded through the Medicaid ConnectCare contract, continued to provide outreach in an effort to improve enrollment of children eligible for Medicaid (ARKids) services. Schools, Head Starts, and other community institutions were involved in these efforts, which were targeted to parts of the state with traditionally high rates of Medicaid eligibility. A bilingual health outreach and promotion specialist paid special attention to Spanish-speaking populations. HCS health educators served as a resource to human service workers based in schools who provide eligibility determinations and assistance with enrollment. Demonstrating the need for all these efforts are recent estimates by Arkansas Advocates for Children and Families which suggest around 25,000 children are eligible for benefits but have never been enrolled.

The Arkansas Finish Line Coalition, composed of a large number of health, social service, and education organizations, continued its campaign to promote a variety of measures related to health coverage for children. These included expansion of Medicaid to more children, creation of electronic enrollment and re-enrollment systems, continuous coverage for children served under traditional Medicaid (ARKids A), and creation of a buy-in option for families just over the income limit. In the last year, some 20,000 children were dropped from Medicaid due to failure to re-enroll, a stark indicator of the need to revamp and streamline re-enrollment processes.

The expansion in eligility limits to 250% FPL for ARKids B approved during the 2009 Arkansas General Assembly failed to materialize due to state general revenue shortfalls.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Health Connections Section provided outreach to vulnerable populations to encourage Medicaid (ARKids) enrollment among those likely to be eligible.		X		
2. The Arkansas Finish Line Coalition advocated for improved enrollment and re-enrollment processes, continuous coverage for ARKids A, and expanded eligibility limits				X
3.				
4.				
5.				
6.				
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9.				
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b. Current Activities

The state Medicaid agency (DHS Division of Medical Services) is considering proposals to find new efficiencies in the system that will preclude the need to severely curtail services. No decrease in eligibility limits is planned, but the expansion to 250% FPL is on hold for an indefinite period of time. Recently passed national health care reform is also being factored into what state Medicaid will be able to offer.

ADH Health Connections continues outreach efforts designed to encourage enrollment among eligible children.
The Arkansas Finish Line Coalition continues to press for improvements in enrollment and re-enrollment processes and for continuous coverage under ARKids A.

c. Plan for the Coming Year

The Health Connections Section is planning to proceed with outreach to vulnerable populations as before.

Family Health will continue to monitor developments within the state Medicaid program for potential adverse impacts on high-risk children. To the extent possible, ADH will advocate for implementation of expanded eligibility limits as soon as possible, as well as for measures that improve enrollment rates for children already eligible under current criteria. Partnerships with the Finish Line Coalition will also continue.

State Performance Measure 3: *The percent of pregnant women counseled for HIV testing.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	75	0	0	68	69
Annual Indicator	67.4	67.4	67.0	66.7	64.4
Numerator	23760	23760	24604	24458	23233
Denominator	35276	35276	36724	36649	36057
Data Source				2007 Arkansas PRAMS	2008 Arkansas PRAMS Survey
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	70	71	72	73	

Notes - 2009
Data source: 2008 PRAMS data are used for 2009 indicator.

Notes - 2008
Data source: 2008 data are from the 2007 PRAMS survey.

Notes - 2007
2007 data source is 2006 PRAMS survey.

a. Last Year's Accomplishments
ADH provided maternity services in 54 Local Health unit sites in 49 counties. Local Health Units, including staff and HHI Coalitions, continued to work within their communities and providers to ensure pregnant women access to prenatal care. Clients are screened for presumptive eligibility Medicaid and ineligible aliens/non-citizens are screened under the State Children's Health Insurance Program for Pregnant Women. These pregnant women are provided referral information to providers and have access to other ADH services. The Local Health Units saw 4,357 pregnant women for initial prenatal appointments in CY 2009. ADH continued to serve the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse, or domestic violence seek the non-judgmental care of the local health unit. Prenatal patients must be provided counseling to determine any risk factors for HIV (Pre-test counseling) even if they opt out of the test. Post-test counseling is also provided. Clients with risk factors are rescreened during their pregnancy, if applicable. ADH clinical policies include a maternity education class for prenatal patients on sexually transmitted infections. The ADH Encounter Managment System reported 3,999 HIV (serum and rapid oral swab HIV tests) tests were performed at initial maternity visits. An additional 741 HIV tests were performed at subsequent and other maternity visits, which would be duplicated clients. UAMS continues to be the referral source for women testing positive for HIV during pregnancy.

Family Planning clients are routinely offered HIV counseling and testing, which facilitates identification of this risk factor in women prior to pregnancy and during the postpartum period. ADH Business Objects reported that 14,717 family planning annual clients received HIV testing in CY 2009. HIV testing is provided in all Local Health Units, even those not providing Women's Health services such as Maternity and Family Planning.

The HIV/STD Section continued to provide outreach education and HIV testing throughout the state. In CY 2009, 61,918 Clients were tested for HIV by the ADH Laboratory (duplicated, men and women). The HIV/STD Section provides data collected to CDC. UAMS ANGELS continued to receive the referrals for women testing positive for HIV. The perinatal transmission prevention program activities are standard protocol for ADH and mandated for all healthcare providers through state statute. As a result, of individuals who were living with HIV/AIDS on December 31, 2009, approximately one percent (1%) were the result of perinatal transmission.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. ADH performed almost 4,000 serum and rapid oral tests for HIV on prenatal patients seen in local health units	X			
2. All prenatal patients seen through ADH received (pre-test) assessment for HIV risk factors and appropriate counseling		X		
3. State-mandated perinatal transmission reduction policies were in force in ADH clinics and for all health care providers in the state				X
4. Pregnant women testing positive for HIV were referred to UAMS		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Arkansas Department of Health (ADH) provides prenatal care which includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, and referral as indicated for high risk care. The ADH will continue to provide prenatal services in counties where the need persists. All ADH staff who provide HIV counseling testing services will attend the HIV Counseling course provided by ADH. HIV antibody counseling and testing will continue to be routinely performed in ADH local health unit clinics where services are provided to men and women. Counseling and testing services are strongly encouraged for persons with HIV exposure risks or risk behaviors. For clients receiving rapid HIV tests, HIV Prevention Counseling Risk Reduction Plan is initiated and updated with each visit related to the rapid test. Within the HIV/STD Section, the HIV Prevention Program works with the HIV Services Program to provide treatment for HIV positive women and infants through the Ryan White funded Sevice Access Sites across Arkansas. The number of sites where these services are available increased from nine to fourteen on April 1, 2010.

c. Plan for the Coming Year
ADH will continue to provide direct patient care services. Voluntary, confidential HIV counseling and testing will continue to be provided by ADH. HIV testing has been expanded to include rapid HIV tests for clients with HIV exposure risk factors. ADH staff will attend the HIV course to provide effective prevention counseling and risk reduction plans for patients. Arkansas has an "OPT Out" legal requirement that pregnant women be tested for syphilis, Hepatitis B, and HIV, or that refusal by the patient be documented in writing. ADH will continue to counsel and instruct pregnant women about HIV and prevention for the unborn infant.

ADH Women's Health programs will continue to participate in the activities and work of the HIV/STD Program.

State Performance Measure 4: *Percentage of children receiving WIC services who are above the 95th percentile on the National Center for Health Statistic weight for height growth charts.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	11.5	13
Annual Indicator	10.7	11.2	11.2	13.9	20.4
Numerator	7876	8781	9553	5364	8935
Denominator	73610	78402	85295	38591	43801
Data Source				Arkansas WIC - PEDNSS (CDC)	Arkansas WIC - PEDNSS (CDC)
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	12	11	10	9.7	

Notes - 2009
The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2008
The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2007
Data are from the PEDNSS report provided by CDC.

a. Last Year's Accomplishments
As in the past, children participating in WIC were prescribed food packages based upon age, but tailored to fit individual needs. All participants received nutrition education designed to address immediate concerns and improve overall health. In addition, one-on-one nutrition counseling with a registered dietician regarding specific nutrition-related health problems continued to be available in local health units.

WIC also administered the Farmers' Market Nutrition Program (FMNP), the mission of which is to encourage the consumption of fresh fruits and vegetables and encourage the development of farmers' markets. Women and children residing in counties with farmers' markets were eligible to receive food coupons which could be redeemed for fresh produce from June through October, 2009.

The implementation of the new WIC MIS, Successful Partners in Reaching Innovative Technology (SPIRIT), was complete at the end of March 2009. This project was funded by the USDA Food and Nutrition Service. SPIRIT is a State Agency Model (SAM) designed to reduce paperwork, improve program integrity and security, improve data accuracy, state efficiency and productivity and reduce system support and maintenance issues. Clinic WIC staff were given SPIRIT training prior to their county roll out.

Value Enhanced Nutrition Assessment (VENA) was implemented in conjunction with SPIRIT rollout. VENA takes a positive approach based on desired health outcomes rather than deficiencies. VENA's emphasis is to improve the current assessment practices by promoting a positive, client-centered approach to obtain information that is used to
-provide individualized nutrition education
-determine nutrition eligibility
-tailor food package
-make appropriate referrals

The Interim Food Package rule was implemented September 28, 2009. This was the first major change to the supplemental foods offered through the program in 30 years. Major changes include the provision of fresh and frozen fruits and vegetables, whole grain foods (such as whole grain bread, tortillas, and brown rice), baby foods and soy beverages. The new food packages contribute to an overall diet that is consistent with established dietary recommendations for infants and children less than 2 years of age, including encouragement of and support for breastfeeding. The packages also contribute to an overall dietary pattern recommended for individuals 2 years of age and older.

All LHU WIC unit staff received training related to the implementation of the Interim Food Package Rule by September, 2009. "WIC Food Packages: Making the Change Work" was an interactive approach to assisting WIC Competent Professional Authorities (CPAs) in assessing participants to prescribe appropriate food packages and nutrition education. Clerical staff received training regarding their roles in implementation of the new food packages.

WIC participants received newsletters at each WIC pick up with information about the new food packages.
All WIC vendors were given intensive training on the new food items that would be purchased with WIC checks.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC participating children received nutrition education and individualized nutrition counseling, as indicated.		X		
2. WIC administered the Farmers' Market Nutrition Program that encouraged consumption of fresh fruits and vegetables.			X	
3. The new WIC information management system (SPIRIT) was implemented statewide.				X
4. Value Enhanced Nutrition Assessment was implemented.				X
5. The new food packages containing healthier food choices were implemented in September 2009.		X		

6. Training of local health unit WIC staff in the new food packages was completed by September 2009.				X
7. Parents of WIC participants received newsletters concerning the food package changes at every scheduled visit.		X		
8.				
9.				
10.				

b. Current Activities

1. WIC continues the activities described above.

2. Revision of WIC policy and procedures to comply with the new MIS, VENA and the new food package rules has been completed.

3. Training is on-going for new staff on SPIRIT and as additional needs are identified.

4. The transition to WIC Electronic Benefit Transmission (EBT) is in the planning stages. Funds have been awarded to conduct an EBT feasibility study.

c. Plan for the Coming Year

1. Continuation of current activities as described.

2. Continuing strategic planning for WIC Electronic Benefit Transmission (EBT) transition.

State Performance Measure 5: *To improve the percent of 14 to 15 year olds on Children's Medical Services (CMS) who state that CMS transition services have helped improve their knowledge and ability to transition into adult life.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8	9	10	22	23
Annual Indicator	7.9	5.5	21.7	21.7	16.7
Numerator	3	10	15	15	6
Denominator	38	182	69	69	36
Data Source				Data is from 2008 AR CSHCN program survey	Data is from 2010 AR CSHCN Survey
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	24	25	26	26	

Notes - 2009

A survey was mailed to parents/guardians of CSHCN in early 2010. Statements on the survey related to transition included: "There is someone who has helped us or is helping us find adult care for my child.? and "We are making plans for the time my child becomes an adult." In addition

"Transition to adulthood" was listed as one of the "Services received from Title V Children's Services staff". Data for this performance measure was derived from the answers to those questions by taking the 36 positive responses to "There is someone who has helped us or is helping us find adult care for my child." and comparing it to the 6 respondents who indicated that "Transition to Adulthood" was one of the services received from Title V Children's Services staff. 6/36 = 17%.

Notes - 2008
This information was taken from a survey completed in 2008 which specifically asked about CMS transition services. Our Transition Survey mailed in the month of the YSHCN 14th birthday does not ask the specific question; however, does ask if there is contact with the CMS Care Coordinator. 27 of 94 respondants in the past year indicated 'Yes' to this question.

Notes - 2007
This data was supplied from responses on our statewide survey done in early 2008 on Transition and program assistance provided by the states' Title V CSHCN staff.

a. Last Year's Accomplishments
The Transition survey mailed to all CSHCN on the database in the month of their 14th birthday generated contact between the Title V CSHCN caseworkers and families on transition-related issues. CSHCN caseworkers continued to provide Transition Tip Sheets to youth on their caseload. Title V CSHCN staff actively participated on the Arkansas Interagency Transition Partnership, a group representing agencies that provide services into adulthood with a focus on assuring that youth with special needs receive the assistance they need for education, job training and support, and living in the community.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Transition surveys mailed to all youth on the database during the month of their 14th birthday to initiate thought & discussion on the need to address specific issues and develop strategies to assist the YSHCN in setting & attaining life goals.		X		
2. CSHCN staff worked with individual YSHCN and other local program representatives to develop individual transition plans.		X		
3. CSHCN staff worked with local councils to staff Transition Fairs at Dept of Ed regional Education Cooperatives. The fairs were attended by youth throughout several school districts served through Special Ed and 504.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Survey mailed to guardians of CYSHCN early Calendar Year 2010. Statements on the survey re: transition included: "There is someone who has helped us or is helping us find adult care for my child" & received a Yes response rate of 32% & "We are making plans for the time my child becomes an adult" & received a Yes response rate of 52%. "Transition to adulthood" was listed as one of "Services received from Title V Children's Services staff". A question asked the respondents to prioritize the needs of the state's CYSHCN. Transition to adulthood was ranked

last under (in order of the ranked priority by respondents) Adequate health insurance; community-based services organized so that families can easily use them; Respite care; families as partners at all levels of care & satisfied with services; receiving coordinated, comprehensive, ongoing care within a medical home; & Dental health. CSHCN staff experience is that transition is not considered until a young person completes their public school education & they & their parent are confronted with where to go now. The ability for the young person to function in society as an adult with all the legal rights & responsibilities of reaching the age of majority has not been considered in many families. A survey is mailed to CSHCN in the month of their 14th birthday to introduce the issue of transition & planning for adulthood. CSHCN staff actively participates on the Arkansas Interagency Transition Partnership (AITP).

c. Plan for the Coming Year

As strategic planning takes place, transition issues must be represented. There appears to be a need for regular communication during the transition period of life in which frequent reminders should be given to youth and their parent/guardian related to public school education issues, options for post-high school education, and employment opportunities. For some, the discussions also must include guardianship issues. Accessing tools that are in use in other states or the development of tools for CSHCN staff to use during this time period must be included in this work.

State Performance Measure 6: *Improve percent of parents responding to the question on Children's Medical Services (CMS) Parent Satisfaction Survey that CMS service coordination teams told them about other services available.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61	63	65	52	56
Annual Indicator	51.9	51.9	55.7	55.7	53.2
Numerator	28	28	151	151	59
Denominator	54	54	271	271	111
Data Source				Data from AR CSHCN program survey	Data from AR CSHCN Survey 2010
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	57	58	58	58	

Notes - 2009

A survey was mailed to parents/guardians of CSHCN early 2010. Several questions related to the issue of knowledge of services available and helping find needed resources; advocacy for the rights and services important to CSHCN; and satisfaction with services received from the Title V CSHCN caseworkers. 59 of 111 respondents indicated they received assistance finding needed resources. 69 of 111 respondents indicated satisfaction with the services received from Title V CSHCN caseworkers.

Notes - 2008

This data is taken from a family survey in early 2008.

Notes - 2007

This data was compiled from responses to our statewide surveys sent out in early 2008.

a. Last Year's Accomplishments

The evaluation for eligibility for other programs begins at the time a caseworker receives a phone call regarding a CSHCN or an application is received in the office. Caseworkers are aware of the program eligibility criteria for numerous programs (e.g. disability categories of Medicaid such as SSI and TEFRA, family support programs such as Title V Family Support/Respite and DDS Special Needs; food and nutrition programs such as WIC, community food pantries, WIC and Food Stamps) and make referrals on a proactive basis. Then, as they work with the CSHCN and their family, referrals are made for other programs as the specific needs become apparent (e.g. DDS Waiver; interagency support programs such as DDS Integrated Supports or CASSP; assistance with purchase of equipment to assure access to a vehicle for individuals in wheelchairs).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff made appropriate referrals for Medicaid based on the family financial status and the level of disability of the CSHCN.		X		
2. Staff made referral for Part C Early Intervention services.		X		
3. Provided assistance in application for short-term emergency assistance from private and public programs.		X		
4. Provided referral and assistance in applying for long-term wrap-around services such as the DDS Waiver.		X		
5. Provided referral and assistance in applying for short-term wrap-around services.		X		
6. Upon request from the parent/guardian, staff assisted with referral and application for residential treatment services.		X		
7. Provided assistance in accessing funding via Title V CSHCN program for equipment or services not covered by Medicaid.	X			
8. Worked in conjunction with other programs (public and private) to provide resources and assistance to families of dually diagnosed children in crisis.		X		
9.				
10.				

b. Current Activities

A survey was mailed to parents/guardians of CYSHCN in early Calendar Year 2010. Several questions related to the issue of knowledge of services available and helping find needed resources; advocacy for the rights and services important to CSHCN; and satisfaction with services received from the Title V CSHCN caseworkers. 59 of 111 respondents indicated they received assistance finding needed resources. 69 of 111 respondents indicated satisfaction with the services received from Title V CSHCN caseworkers. CSHCN staff serve as a referral source for access to Title V program benefits (Title V Family Support/Respite and purchase of services not covered by Medicaid, as funding allows) and DDS programs (DDS Waiver, Special Needs, Integrated Supports and ICF/MR). The staff also worked on referral and intake for two one-time programs offered through DDS this year. They were the Special Needs Autism program and the ARRA Home and Vehicle modification program. The programs generated a large number of referrals and contact with applicants. As each application was reviewed, the caseworker evaluated if other services may be available to the applicant beyond the program for which they were applying.

c. Plan for the Coming Year

CSHCN staff will continue to provide information, referral and intake for Title V CSHCN and DDS programs. The completion of strategic planning should assist in the gathering of or development of tools needed by CSHCN staff.

State Performance Measure 7: *The percent of public school students overweight greater than 95th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	7	5	20.4	20.2
Annual Indicator	20.8	20.5	20.6	20.5	20.4
Numerator	77351	75596	75544	36599	36560
Denominator	371367	369416	366801	178181	179007
Data Source				Arkansas Center for Health Improvement	Arkansas Center for Health Improvement
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	19.8	19.6	19.4	

Notes - 2009
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Six (Fall 2008 - Spring 2009).

The change in the numerator and denominator is a result of a legislative change in assessment periodicity established by Act 201 of 2007 to only include students in even-number grades (K, 2, 4, 6, 8, and 10).

Notes - 2008
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Five (Fall 2007 - Spring 2008).

The change in the numerator and denominator is a result of a legislative change in assessment periodicity established by Act 201 of 2007 to only include students in even-number grades (K, 2, 4, 6, 8, and 10).

Notes - 2007
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Four (Fall 2006 - Spring 2007).

Beginning in 2007, BMI measurements are done for every other grade - even grades from Kindergarten through grade 10. Some schools with pre-K programs are assessing these children as well.

The 2006 notes are in error regarding tracking of the same students year to year. Rather percentages are based on individual grades each year.

a. Last Year's Accomplishments
In late 2009, the UAMS College of Public Health completed its assessment of the sixth year of activities as a result of Arkansas Act 1220 of 2003, which mandated BMI measurements and a

number of other anti-obesity efforts in Arkansas public schools. The report shows that school district policies related to nutrition have continued to improve. More schools are offering low-fat or skim milk, while fewer offer whole milk. Since 2004, many more schools have prohibited "junk foods" from being offered in cafeteria lines, at student parties, in school stores, and in vending machines. Students also continued to report significantly less access to food and beverage machines. In 2009, only 23% of students reported access to a food vending machine at school, compared to 64% in 2004. In 2009, 50% of students reported making no beverage machine purchases in the preceding month, compared to 22% in 2004. Perhaps even more significantly, for the first time in the six years of program evaluation, students reported eating less often at fast-food restaurants.

The Child Health Advisory Committee (CHAC), which was established as part of Act 1220, continued to meet monthly to discuss additional strategies to combat childhood obesity. In 2009 the committee developed a large set of recommendations for the Arkansas Board of Education, the Arkansas Department of Health and other relevant state agencies for each of eight Guiding Principles based on the eight components of the Coordinated School Health model.

The data entry system for BMI measurements obtained in schools was updated in 2009. This system is a web-based program operated through the Arkansas Center for Health Improvement, which allows automatic calculation of BMI's when weight and height data are entered. ADH Community Health Promotion Specialists (CHPS's) and Community Health Nurse Specialists (CHNS's) trained school personnel on use of the updated system in early 2009. The Arkansas Center for Health Improvement continued to compile and analyze BMI measurements obtained by public schools in accordance with Act 1220.

The Arkansas Department of Education (ADE) received initial funding for the Fresh Fruit and Vegetable Program in the 2008-09 school year. Goals of the program are to create healthier school environments by providing healthier food choices, to increase children's consumption of fruits and vegetables, and to expand the variety of fruits and vegetables to which children are exposed. Children receive free fresh fruits and vegetables throughout the school day, along with nutrition education. The program also encourages community partnerships. During the 2008-09 school year, 30 elementary schools with 11,532 students participated. Participating schools were selected following an RFP process.

Coordinated School Health sites were also involved in anti-obesity activities. Prior to the start of the current (2009-10) school year, most of the 33 CSH school districts applied for funding under the umbrella of the Child Wellness Intervention Project (CWIP), sponsored by the Tobacco Settlement Commission and other partners. To be eligible for CWIP grants, schools had to commit to increasing physical education time and to implementing the SPARK P.E. curriculum and fitness assessment using Fitnessgram by trained P.E. teachers in either K-2, 3-6, or middle school grade categories. Arkansas Children's Hospital provided the HealthTeacher.com curriculum to almost all the CSH schools (and a few non-CSH schools) for use in both elementary and middle schools. As part of CWIP, training in these curricula as well as the PE4Life model was also provided to school and community leaders. A total of 57 schools, both CSH and non-CSH, were funded under CWIP.

Two other CSH school districts, Hot Springs and Batesville, received separate funding through the Arkansas Coalition for Obesity Prevention (ARCOP) Growing Healthy Communities Initiative. These efforts target both schools and community leaders to create improved access to healthy foods as well as community environments that foster safe physical activity.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. As a result of policies enacted pursuant to Act 1220 of 2003, students' access to food and beverage machines continued to decline, and students reported eating fast food less often				X
2. The Child Health Advisiory Committee released a large set of recommendations to the Board of Education and Arkansas Department of Health based upon the eight Coordinated School health components				X
3. Body mass index measurements were collected on students in even-numbered grades K-10 in all public schools, with results reported to parents			X	
4. The ADE Fresh Fruit and Vegetable Program served over 11,500 students in the 2008-09 school year, and over 19,500 during the 2009-2010 school year			X	
5. The Child Wellness Intervention Project (CWIP) funded 57 schools to increase PE time and implement several physical education curricula and a fitness assessment tool		X		
6. The Arkansas Coalition for Obesity Prevention funded a number of communities, including two CSH school districts, to participate in the Growing Healthy Communities initiative				X
7.				
8.				
9.				
10.				

b. Current Activities

A response from the Arkansas Board of Education to the recent recommendations made by the Child Health Advisory Committee (CHAC) is pending. CHAC continues to consider and recommend policies and programs to ADH and ADE relative to fitness and nutrition. The group, composed of a multidisciplinary group of health, nutrition, and education professionals from public and private sectors, meets monthly.

BMI measurements continue to be obtained from public school students in even-numbered grades, K-10.

The Fresh Fruit and Vegetable Program continues to grow. In the current (2009-10) school year, 47 schools representing 19,574 students are participating. The Child Nutrition Unit at ADE is currently reviewing program proposals from schools for the 2010-2011 school year.

CSH schools continue to focus on health and academic achievement for the whole child using the Coordinated School Health (CSH) model. For the second year, CSH is recognizing a district with a "Healthy School Board Award." CWIP-funded projects as outlined above are completing their first full academic year and schools are preparing to apply for next year's (2010-11) funding. Data collection required for the planned CWIP evaluation is also proceeding. Two CSH school districts, Batesville and Hot Springs, continue Growing Healthy Communities activities through support from the Arkansas Coalition for Obesity Prevention.

c. Plan for the Coming Year

School districts will continue to consider new policies which reduce students' access to unhealthy foods, and improve opportunities for physical activity within the school environment. The Child Health Advisory Committee will continue to consider policy changes for schools that promote better nutrition and increased physical activity.

BMI measurements will continue in schools as per legislative mandate. Other aspects of Act 1220 will continue to be monitored and evaluated by the UAMS College of Public Health under a grant

from the Robert Wood Johnson Foundation.

The Fresh Fruit and Vegetable Program will have approximately $1.5 million of funding available to schools for the 2010-2011 school year. The Child Nutrition Unit at ADE anticipates funding an even larger number of schools in the coming year (perhaps 70-75). As stated previously, interested schools have already submitted proposals.

Coordinated School Health schools will continue to be heavily involved in CWIP-sponsored anti-obesity activities. Data collected from the first year's efforts should be available next year as part of Year One evaluation.

In the summer of 2010, obesity prevention education targeted to school nurses ("S.C.O.P.E.") will be offered by the Arkansas Department of Education for continuing education credit.

State Performance Measure 8: *The percentage of at-risk for overweight children in Arkansas public schools.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	9	7	5	17.1	17
Annual Indicator	17.2	17.1	17.2	17.4	17.2
Numerator	63943	63315	63059	30917	30840
Denominator	372369	369416	366801	178181	179007
Data Source				Arkansas Center for Health Improvement	Arkansas Center for Health Improvement
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16.8	16.7	16.6	16.5	

Notes - 2009
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Six (Fall 2008 - Spring 2009).

The change in the numerator and denominator is a result of a legislative change in assessment periodicity established by Act 201 of 2007 to only include students in even-number grades (K, 2, 4, 6, 8, and 10).

Notes - 2008
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Five (Fall 2007 - Spring 2008).

The change in the numerator and denominator is a result of a legislative change in assessment periodicity established by Act 201 of 2007 to only include students in even-number grades (K, 2, 4, 6, 8, and 10).

Notes - 2007
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Four (Fall 2006 - Spring 2007).

a. Last Year's Accomplishments

In late 2009, the UAMS College of Public Health completed its assessment of the sixth year of activities as a result of Arkansas Act 1220 of 2003, which mandated BMI measurements and a number of other anti-obesity efforts in Arkansas public schools. The report shows that school district policies related to nutrition have continued to improve. More schools are offering low-fat or skim milk, while fewer offer whole milk. Since 2004, many more schools have prohibited "junk foods" from being offered in cafeteria lines, at student parties, in school stores, and in vending machines. Students also continued to report significantly less access to food and beverage machines. In 2009, only 23% of students reported access to a food vending machine at school, compared to 64% in 2004. In 2009, 50% of students reported making no beverage machine purchases in the preceding month, compared to 22% in 2004. Perhaps even more significantly, for the first time in the six years of program evaluation, students reported eating less often at fast-food restaurants.

The Child Health Advisory Committee (CHAC), which was established as part of Act 1220, continued to meet monthly to discuss additional strategies to combat childhood obesity. In 2009 the committee developed a large set of recommendations for the state Board of Education, the Arkansas Department of Health and other relevant state agencies for each of eight Guiding Principles based on the eight components of the Coordinated School Health model.

The data entry system for BMI measurements obtained in schools was updated in 2009. This system is a web-based program operated through the Arkansas Center for Health Improvement, which allows automatic calculation of BMI's when weight and height data are entered. ADH Community Health Promotion Specialists (CHPS's) and Community Health Nurse Specialists (CHNS's) trained school personnel on use of the updated system in early 2009. The Arkansas Center for Health Improvement continued to compile and analyze BMI measurements obtained by public schools in accordance with Act 1220.

The Arkansas Department of Education (ADE) received initial funding for the Fresh Fruit and Vegetable Program in the 2008-09 school year. Goals of the program are to create healthier school environments by providing healthier food choices, to increase children's consumption of fruits and vegetables, and to expand the variety of fruits and vegetables to which children are exposed. Children receive free fresh fruits and vegetables throughout the school day, along with nutrition education. The program also encourages community partnerships. During the 2008-09 school year, 30 elementary schools with 11,532 students participated. Participating schools were selected following an RFP process.

Coordinated School Health sites were also involved in anti-obesity activities. Prior to the start of the current (2009-10) school year, most of the 33 CSH school districts applied for funding under the umbrella of the Child Wellness Intervention Project (CWIP), sponsored by the Tobacco Settlement Commission and other partners. To be eligible for CWIP grants, schools had to commit to increasing physical education time and to implementing the SPARK P.E. curriculum and fitness assessment using Fitnessgram by trained P.E. teachers in either K-2, 3-6, or middle school grade categories. Arkansas Children's Hospital provided the HealthTeacher.com curriculum to almost all the CSH schools (and a few non-CSH schools) for use in both elementary and middle schools. As part of CWIP, training in these curricula as well as the PE4Life model was also provided to school and community leaders. A total of 57 schools, both CSH and non-CSH, were funded under CWIP.

Two other CSH school districts, Hot Springs and Batesville, received separate funding through the Arkansas Coalition for Obesity Prevention (ARCOP) Growing Healthy Communities Initiative. These efforts target both schools and community leaders to create improved access to healthy foods as well as community environments that foster safe physical activity.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. As a result of policies enacted pursuant to Act 1220 of 2003, students' access to food and beverage machines continued to decline, and students reported eating fast food less often				X
2. The Child Health Advisiory Committee released a large set of recommendations to the Board of Education and Arkansas Department of Health				X
3. Body mass index measurements were collected on students in even-numbered grades K-10 in all public schools, with results reported to parents			X	
4. The ADE Fresh Fruit and Vegetable Program served over 11,500 students in the 2008-09 school year, and over 19,500 during the 2009-2010 school year			X	
5. The Child Wellness Intervention Project (CWIP) funded 57 schools to increase PE time and implement several physical education curricula and a fitness assessment tool		X		
6. The Arkansas Coalition for Obesity Prevention funded a number of communities, including two CSH school districts, to participate in the Growing Healthy Communities initiative				X
7.				
8.				
9.				
10.				

b. Current Activities

A response from the Arkansas Board of Education to the recent recommendations made by the Child Health Advisory Committee (CHAC) is pending. CHAC continues to consider and recommend policies and programs to ADH and ADE relative to fitness and nutrition. The group, composed of a multidisciplinary group of health, nutrition, and education professionals from public and private sectors, meets monthly.

BMI measurements continue to be obtained from public school students in even-numbered grades, K-10.

The Fresh Fruit and Vegetable Program continues to grow. In the current (2009-10) school year, 47 schools representing 19,574 students are participating. The Child Nutrition Unit at ADE is currently reviewing program proposals from schools for the 2010-2011 school year.

CSH schools continue to focus on health and academic achievement for the whole child using the Coordinated School Health (CSH) model. For the second year, CSH is recognizing a district with a "Healthy School Board Award." CWIP-funded projects as outlined above are completing their first full academic year and schools are preparing to apply for next year's (2010-11) funding. Data collection required for the planned CWIP evaluation is also proceeding. Two CSH school districts, Batesville and Hot Springs, continue Growing Healthy Communities activities through support from the Arkansas Coalition for Obesity Prevention.

c. Plan for the Coming Year

School districts will continue to consider new policies which reduce students' access to unhealthy foods, and improve opportunities for physical activity within the school environment. The Child Health Advisory Committee will continue to consider policy changes for schools that promote better nutrition and increased physical activity.

BMI measurements will continue in schools as per legislative mandate. Other aspects of Act 1220

will continue to be monitored and evaluated by the UAMS College of Public Health under a grant from the Robert Wood Johnson Foundation.

The Fresh Fruit and Vegetable Program will have approximately $1.5 million of funding available to schools for the 2010-2011 school year. The Child Nutrition Unit at ADE anticipates funding an even larger number of schools in the coming year (perhaps 70-75). As stated previously, interested schools have already submitted proposals.

Coordinated School Health schools will continue to be heavily involved in CWIP-sponsored anti-obesity activities. Data collected from the first year's efforts should be available next year as part of Year One evaluation.

In the summer of 2010, obesity prevention education targeted to school nurses ("S.C.O.P.E.") will be offered by the Arkansas Department of Education for continuing education credit.

State Performance Measure 9: *The percent of women smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	11	11	15	14.8
Annual Indicator	16.2	15.9	15.7	15.3	14.8
Numerator	6370	6530	6504	6188	5635
Denominator	39210	40966	41341	40489	38030
Data Source				2008 Birth Certificates	2009 Birth Certificates
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	14.4	14	13.5	13.4	

Notes - 2009
Source: 2009 Birth Certificate Data, Health Statistics Branch, Arkansas Department of Health

Notes - 2008
Source: 2008 Birth Certificate Data, Health Statistics Branch, Arkansas Department of Health

Notes - 2007
Source: 2007 Birth Certificate Data, Health Statistics Branch, Arkansas Department of Health

a. Last Year's Accomplishments
Beginning October 1, 2008, the Arkansas Tobacco Quitline began operating through Free & Clear, Inc. As one of the nation's leading tobacco cessation treatment providers, Free & Clear's Quit for Life Program assists ADH's cessation services. Two toll free numbers and a fax referral program are offered. Women who are pregnant are eligible for a specialized cessation program with additional benefits.

All maternity, family planning, WIC and STD clients seen in the ADH's local health units were, and continue to be, screened for tobacco use. This is a required question in the history and counseling components of the Women's Health and WIC programs. Women's Health Programs include up-to-date smoking cessation policies as guidelines for the Public Health Nurse. ADH Nurse Practitioners and Clinicians utilize the UAMS ANGELS tobacco dependence/cessation guidelines for pregnant, postpartum and family planning clients. Programs provide written information in English or Spanish on the risks of smoking and information on resources for

cessation. Family Planning and Maternity clients receive education on the effects of tobacco/smoking in pregnancy and the identification of this behavior as a preconception risk.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Women seen for maternity, family planning, WIC, and STD services were all screened for tobacco use			X	
2. ADH Women's Health Nurse Practitoners utilized ANGELS tobacco dependence/cessation guidelines for pregnant and postpartum women		X		
3. Public health nurses provided written information (in English and Spanish) to maternity and family planning patients on the effects of tobacco use and the preconception/postconception risks posed		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

ADH local health unit staff must ask tobacco use status of all patients, advise them to quit and refer those willing to quit to the Arkansas Tobacco Quitline (ATQ) by the faxed referral program. The ATQ is a free, proactive referral system that provides assistance to those over age 16 that are willing to quit tobacco within 30 days. Registrants can contact the ATQ seven days a week, 7am-2am. All pregnant women, those planning a pregnancy within 3 months or breastfeeding who are using tobacco are eligible for a special program to quit. ATQ takes a woman centered approach, balancing the benefits of quitting for both the fetus and the woman. Quitline coaches are supportive and empathetic with pregnant tobacco users. In addition, Quitline coaches provide information about pharmacotherapy options specific to pregnant women. Women are encouraged to engage in meaningful discussion with their physician about the pros and cons of using pharmacotherapy to aid their cessation effort.

In addition to the telephone access line to the ATQ Quitline coaches, the ATQ Pregnancy Program includes up to 10 calls by the Quitline Coach with relapse sensitivity via phone or online tailored to the specific needs of each tobacco user with the first 5-6 calls made within 60-90 days of enrollment; one call within 30 days before the woman's due date; at least 2 calls postpartum and content structured for pregnant smokers.

c. Plan for the Coming Year

Tobacco prevention and cessation education will continue to be provided in the ADH local health units and through the outreach efforts of the Tobacco Cessation Program. The Arkansas Tobacco Quitline will continue to provide assistance to tobacco users via phone and online. ATQ Pregnancy Program will continue to provide the specialized assistance program that includes structured content for pregnant smokers.

State Performance Measure 10: *To increase the percentage of ADH Family Planning clients receiving nutritional counseling during an initial or annual visit in the Family Planning clinics.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		0	80	86	87
Annual Indicator	73.7	75.6	84.0	83.9	89.9
Numerator	36537	35779	38439	39398	43591
Denominator	49582	47341	45770	46968	48471
Data Source				ADH: Business Objects	ADH: Business Objects
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	88	89	90	91	

Notes - 2009
Source is Business Objects: family planning encounters that reported Nutritional Counseling-non WIC.

Notes - 2008
Source is Business Objects: family planning encounters that reported Nutritional Counseling-non WIC and 34 Nutrition assessments.

Notes - 2007
Source is Business Objects: family planning encounters that reported Nutritional Counseling-non WIC and 34 Nutrition assessments.

a. Last Year's Accomplishments
The ADH Encounter System reported for CY 2009 a total of 77,229 Family Planning patients received Nutrition Counseling Non-WIC and 4 reported Nutrition Assessments. A total of 43,746 reported Nutrition Counseling Non-WIC at the Family Planning Annual exam. Women and men in the Family Planning clinics were screened for weight, height and Body Mass Index (BMI) calculations at the Annual Exam and as needed for subsequent visits. Written educational pamphlets were offered in English and Spanish in addition to individual counseling by the Local Health Unit Nurses and Clinicians. Family Planning services are offered in 86 Local Health Units.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Over 77,000 family planning patients received nutritional counseling services		X		
2. Body mass index was calculated routinely at all Family Planning Annual Exams conducted in local health units	X			
3. Written materials (in English and Spanish) on healthy nutrition practices were distributed by public health nurses		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
ADH Local Health Units continue to provide BMI assessment, Nutrition Education/Counseling and emphasis on healthy lifestyles. Preconception identification of BMI>30 provides an opportunity to further educate the client on this prenatal risk. ADH employees are encouraged to utilize the Arkansas Healthy Employees Lifestyle (AHELP) and Blue and You Fitness Challenge. AHELP is a comprehensive effort to clearly define specific areas where behavioral changes can lead to a healthier lifestyle. The Healthy Arkansas website provides strategies to reduce and/or eliminate tobacco use, obesity and physical inactivity with information on nutrition, physical activity and smoking cessation. Home Town Health has actively participated in workgroups and key events targeting obesity prevention, nutrition and physical activity in communities throughout Arkansas. Community Health Nurse Specialists have developed CD's for BMI training, provided information on fitness challenges and health fairs, and partnered with schools and school nurses to address health-related issues in Arkansas's public schools.

c. Plan for the Coming Year
Efforts to identify resources for referral for nutritional counseling will continue. Family Planning clients will continue to receive BMI assessments at their initial and annual visits. ADH will continue to look for ways to develop partnerships to stimulate plans and activities to reduce obesity and its risks. Community Health Nurse Specialists will continue efforts in the public schools to address health related issues such as nutrition, physical activities and tobacco. Local Home Town Health Improvement coalitions will continue to work with communities to address obesity, chronic disease and health disparities.

E. Health Status Indicators

Introduction
Health status indicators provide additional exploration of certain problems only touched upon in performance measures, such as childhood injury and premature births. The indicators also provide in-depth analysis of key demographic variables, such as breakdowns by age and race/ethnicity, or by residence in
urban vs. rural areas. These analyses are very useful for planning purposes, helping to direct resources to groups most in need as well as to groups for whom successful intervention will lead to more favorable outcomes for the state as a whole. When studied over time, the indicators afford one a sense of shifting demographic trends within the state. Through examination of total population numbers, these analyses help remind the program that the goal is to improve every person's health, not just those served directly by program activities.

Indicators that include rates over a five-year period are particularly useful in helping monitor trends of various conditions and problems. When major initiatives have been introduced to address a given problem, such rates can also be useful in helping to establish whether the intervention was effective (although other concurrent activities, events, and mitigating circumstances in the state must also be factored in before drawing sweeping conclusions).

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.1	9.1	9.5	9.2	9.0
Numerator	3546	3667	3945	3788	3551
Denominator	39101	40203	41380	41168	39261
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data source: 2009 birth certificate data for fiscal year 2009 - October 1, 2008 through September 30, 2009.

Notes - 2008
Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007
Data source: 2007 birth certificate data for fiscal year 2007 - October 1, 2006 through September 30, 2007.

The sharp increase in low birth weight rate for Arkansas is clearly noted. We are studying this phenomenon. It appears that the largest increases have occurred among the higher birth weight portion of this group - 2000 to 2500 grams. This is also reflected in increases in the percentage of all births that occur late preterm - 34-37 weeks. These findings need assessment in detail. Some questions we are looking into: are we inducing labor or performing c-sections too early?

Narrative:
The low birth weight (LBW) rate has inched down slightly since 2007 but overall is little changed over the past five years. Reduction of LBW has traditionally been extraordinarily difficult to achieve, with no public health strategies known to work well. Focusing on elimination of specific risk factors associated with LBW, such as smoking during pregnancy, has been pursued with varying success. Promotion of improved prenatal nutrition as part of early and regular prenatal visits has also been tried. Reduction of births to adolescents may also have an impact, as teens are much more likely to have LBW babies. Nonetheless, prevention of preterm births, the major cause of LBW, has overall proven very frustrating. Part of this frustration lies in the persistent disparity between African Americans and Whites with respect to rates of premature birth.

The Arkansas Department of Health offers prenatal clinics in 54 sites around the state based on local needs, as described in other sections of this document. Aggressive attempts to promote smoking cessation and to bolster maternal nutrition are undertaken in all these sites. ADH Women's Health Nurse Practitioners and Public Health Nurses consult with maternal-fetal medicine specialists at UAMS about questionable findings and refer high risk patients to UAMS for ongoing prenatal care. Although actual prevention of prematurity and LBW is often not possible, the ANGELS program appears to have succeeded in improving outcomes for high risk mothers and infants through education and a regionalized care strategy.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.4	7.5	7.8	7.4	7.3
Numerator	2811	2907	3109	2951	2776
Denominator	37914	38971	40063	39858	38076

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data source: 2009 birth certificate data for fiscal year 2009 - October 1, 2008 through September 30, 2009.

Notes - 2008
Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007
Data source: 2007 birth certificate data for fiscal year 2007 - October 1, 2006 through September 30, 2007.

It is clear that the phenomenon of increases in low weight births can not be explained by multiples and assisted reproductive therapy alone. We also notice an increase in late preterm births. Please see comments under the total low birth weight rate measure.

Narrative:
See discussion under HSI 01A. Subtracting multiple births associated with LBW from the proportion of all LBW births does little to change the overall trend seen. The same risk factors of prenatal smoking/substance use, race, low socio-economic status, poor prenatal nutrition, and young maternal age all apply.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	1.8	1.8	1.7	1.7
Numerator	678	726	762	698	662
Denominator	39101	40203	41380	41168	39261
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data source: 2009 birth certificate data for fiscal year 2009 - October 1, 2008 through September 30, 2009.

Notes - 2008
Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007
Data source: 2007 birth certificate data for fiscal year 2007 - October 1, 2006 through September 30, 2007.

The increase in births below 1500 grams is also noted and is of great concern. We need to look also at the percentage of births at a gestational age of 32 weeks to see if that parallels the birth weight trend. These analyses will be made carefully over the next few months to clarify our developing needs.

Narrative:
See discussion under HSI 01A. As with LBW, rates of very low birth weight (VLBW) have changed very little over the years. Effective strategies to prevent prematurity remain elusive. Although obviously very important for many reasons, provision of prenatal care has not been shown to impact these rates much. Many women who deliver prematurely have no overt warning signs or risk factors beforehand, making a targeted approach less effective. Still, for those with identified risk factors, referral to a source of high risk pregnancy care has certainly been found beneficial. Particularly for very preterm infants, education of providers and regionalization of care engendered through the UAMS-based ANGELS programs has improved outcomes.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.4	1.4	1.4	1.3	1.3
Numerator	520	563	573	537	506
Denominator	37914	38971	40063	39858	38076
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
Data source: 2009 birth certificate data for fiscal year 2009 - October 1, 2008 through September 30, 2009.

Notes - 2008
Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007
The trend for very low birth weight among singleton births seems pretty flat. Thus it seems that our increases in low birth weight rates are impacted more by moderately LBW infants and late preterm births. We are investigating this finding.

Narrative:
See discussion under HSI 02A. Multiple births contribute somewhat to total VLBW deliveries, but the trend for singleton VLBW births is the same as for the total - unchanged over time.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	16.5	13.2	11.4	10.3	8.2
Numerator	92	75	66	60	48
Denominator	557472	569943	579442	583073	583073
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2008 population estimate 0 - 14 years used for 2009 rate

The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

Notes - 2008
2007 population estimate 0 - 14 years used for 2008 rate

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

If, however, this rate is accurate, then the apparent decline in death rates in the past two years to children under 14 is gratifying. Certainly a great deal more public emphasis at community level has been brought to bear through programmatic efforts around seat belt use and fire burn prevention. We need to assess future numbers to see if this dramatic drop holds up. It may be a "bounce," and not reflect a true trend.

Notes - 2007
The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

If, however, this rate is accurate, then the apparent decline in death rates to children under 14 is gratifying. Certainly a great deal more public emphasis at community level has been brought to bear through programmatic efforts around seat belt use and fire burn prevention. We need to assess future numbers to see if this dramatic drop holds up. It may be a one-year "bounce."

Narrative:
Although data from 2009 remain highly provisional, there appears to be a clear downward trend in injury mortality among children and young adolescents in Arkansas. Such a trend is most welcome in a state that has suffered excess injury mortality for many, many years. One possible contributing factor is the passage of a primary enforcement seat belt law last year. However, the downward trend had obviously begun prior to the new legislation, and much credit must go to the Injury Prevention Center, housed at Arkansas Children's Hospital under the direction of Dr. Mary Aitken. Dr. Aitken's staff has relentlessly promoted safety on a number of fronts, including motor vehicle (passenger restraints, ATV's, pedestrian, bicycles), residential house fires (smoke alarms, fire escape plans), drowning (water/boating), playground, and home safety.

Adding to the momentum, development of the trauma system mandated by the state legislature last year is moving ahead rapidly. A Trauma Section has been created within the ADH Injury Prevention and Control Branch and a Section Chief has been hired. Many experts both within and outside the Arkansas Department of Health have been conferring to plot the arc of the new system, which will also include a trauma registry as well as certain primary prevention activities. Although it will take several years for the system to fully mature, hopes are high that injury outcomes will improve even further over the course of that development.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.7	7.5	5.7	3.9	3.3
Numerator	32	43	33	23	19
Denominator	557472	569943	579442	583073	583073
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2008 population estimate 0 - 14 years used for 2009 rate

The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate

exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

Notes - 2008
2007 population estimate 0 - 14 years used for 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

However, if this rate is accurate, the fact that this trend is showing a sharp drop in deaths due to motor vehicle crashes goes along with new public emphasis on seat belt use, and among new awareness of all terrain vehicle dangers. This pattern goes along with programmatic efforts.

Notes - 2007
The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

However, if this rate is accurate, the fact that this trend is showing a sharp drop in deaths due to motor vehicle crashes goes along with new public emphasis on seat belt use, and among new awareness of all terrain vehicle dangers. This pattern goes along with programmatic efforts.

Narrative:
After a peak in 2006, motor vehicle crash deaths to children appear to be declining, although data for 2009 are highly provisional. A primary enforcement seat belt law was passed in 2009, but the onset of the downward trend appears to pre-date that measure. As with the overall decline in unintentional injury deaths to Arkansas children, much credit must go to the Injury Prevention Center at Arkansas Children's Hospital. The Injury Prevention Center has promoted passenger safety through safety seat checkups around the state; training of local personnel to become certified child passenger technicians; safety seat giveaways; safety "showers" at which expectant mothers receive safety equipment and information; presentations at schools, health fairs, and to community groups to promote seat belt usage; and through advocacy for public policy. The Injury Prevention Center has also developed specific programming for ATV safety (a major concern for Arkansas youth), in addition to bicycle and pedestrian safety.

Adding to the positive trend, expectations are high that development of a statewide trauma

system (already underway) will further reduce injury mortality (see HSI 03A).

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	44.8	49.2	46.8	37.0	21.6
Numerator	178	191	180	142	83
Denominator	397584	388023	384967	383568	383568
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009
2008 population estimate 0 - 14 years used for 2009 rate

The 2009 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2009.

Notes - 2008
2007 population estimate 0 - 14 years used for 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

However, if this rate is accurate and although we need to update our denominator data, the numbers of death to youth 15-24 seem to be sharply down, again showing agreement with the experience of children under 15. Population-wide public awareness messages could well impact both age groups.

Notes - 2007

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

However, if this rate is accurate, the numbers of death to youth 15-24 seem to be sharply down, again showing agreement with the experience of children under 15. Population-wide public awareness messages could well impact both age groups.

Narrative:
Provisional data from 2009 suggests a marked reduction in motor vehicle crash deaths among adolescents and young adults in Arkansas. The decline appears to have started in 2008, although those figures are not yet final. The tremendous decrease in 2009 may relate to the state laws passed early that year requiring use of seat belts (primary enforcement), graduated licensing for younger drivers (16-18), and a ban on cell phone use for drivers <21 years old. These legislative acts were felt to represent extremely important measures for the state at the time, and their impact may already be manifest. In addition, the poor economic conditions which emerged in 2009 may have affected the death rate from motor vehicle crashes as a result of fewer teens having access to automobiles and/or fewer miles being driven overall.

The statewide trauma system established in the same 2009 state legislative session is developing rapidly and should contribute even further to declines in injury mortality (see HSI 03A).

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	367.4	372.8	366.7	349.9	329.6
Numerator	2048	2125	2125	2040	1922
Denominator	557472	569943	579442	583073	583073
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: 2008 Hospital Discharge Data System and 2008 population estimates less than 14 years.

2008 is latest available data.

Notes - 2008
Data source: 2007 Hospital Discharge Data System and 2007 population estimates less than 14 years.

2007 is latest available.

Notes - 2007
Data source: 2006 Hospital Discharge Data System and 2006 population estimates less than 14 years.

2006 is latest available. We will make no other comment on this trend.

Narrative:
Non-fatal severe injuries to Arkansas children have not declined as much as fatal injuries in recent years, signifying the need for additional primary prevention efforts. Still, even the 10% reduction seen since 2005 is encouraging. Since the 2009 rate was calculated using 2008 data, the impact of the primary enforcement seat belt law passed in 2009 would not yet be evident, but should become manifest in the next one to two years. Nonetheless, continued efforts by the Injury Prevention Center at Arkansas Children's Hospital along with work by the ADH Injury Prevention and Control Branch on a number of different childhood safety issues must certainly be having a positive impact.

Although the trauma system per se will not directly improve this measure, funds that were set aside in the same enabling legislation for use on primary injury prevention activities may benefit this health status indicator. Current plans for use of these funds include hiring of health education specialists in all five public health regions. Public awareness of injury prevention measures -- and laws that seek to encourage safer behaviors -- is undoubtedly a key component of any effective injury prevention strategy.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	61.7	57.9	57.0	55.4	47.7
Numerator	344	330	330	323	278
Denominator	557472	569943	579442	583073	583073
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: 2008 Hospital Discharge Data System and 2008 population estimates less than 14 years.

2008 is latest available data.

Notes - 2008
Data source: 2007 Hospital Discharge Data System and 2007 population estimates less than 14 years.

2007 data are the latest available.

Notes - 2007
Data source: 2006 Hospital Discharge Data System and 2006 population estimates less than 14 years.

2006 data are the latest available.

We will withhold comment until later data become available.

Narrative:
See discussion for HSI 04A. Hospitalizations for motor vehicle crash injuries in children have trended downward for several years, but showed a marked decline in "2009" (calculated using 2008 data). Again, this decrease pre-dated the passage of the primary enforcement seat belt law and other driving-related laws in 2009, so other factors were at play. As with other recent reductions in injury rates, much credit goes to the Injury Prevention Center at Arkansas Children's Hospital, which has devoted quite a bit of attention to motor vehicle crash injuries under the direction of Dr. Mary Aitken. Given the new state laws and the additional primary prevention activities planned for the state as part of the trauma system act, further improvement in this measure is highly anticipated over the next few years.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	155.7	156.4	157.7	153.8	134.3
Numerator	619	607	607	590	515
Denominator	397584	388023	384967	383568	383568
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Data source: 2008 Hospital Discharge Data System and 2008 population estimates less than 14 years.

2008 is latest available data.

Notes - 2008
Data source: 2007 Hospital Discharge Data System and 2007 population estimates 15-24 years.

2007 are the latest available.

Notes - 2007
Data source: 2006 Hospital Discharge Data System and 2006 population estimates 15-24 years.

2006 are the latest available.

Narrative:
The 2009 rate shown above marks the first year of significant improvement in motor vehicle injury hospitalizations for Arkansas adolescents and young adults. As with HSI 04A and 04B, the rate is based on discharge data from 2008 and thus the injuries counted pre-date passage of the primary enforcement seat belt law in 2009. Also passed that year were laws requiring graduated licensing of younger (16-18) drivers and a ban on cell phone use for drivers less than 21 years old. These significant acts will certainly reduce the number of serious injuries and may have already begun to prevent fatalities from motor vehicle crashes (see HSI 03C). As previously suggested, the poor economy of 2009 may have also affected crash rates and resultant injuries through fewer teens having access to automobiles and/or fewer miles being driven.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	31.0	30.2	34.3	46.5	47.6
Numerator	2961	2879	3299	4471	4570
Denominator	95546	95410	96115	96050	96050
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 population estimate of female population 15-19 years used for 2009 indicator.

Notes - 2008
2007 population estimate of female population 15-19 years used for 2008 indicator.

Notes - 2007
2006 population estimate of female population 15-19 years used for 2007 indicator.

Even though the population denominator has not been updated, our concern for the steady rise in chlamydia positivity among tested young women is of very great concern. At the moment we lack a clearly proven methodology to address this trend. We will bring new emphasis to treating partners by sending medications home with the women who have positive tests. So far, we have not seen results on a special project in Washington DC in which an Internet page was used to enhance public awareness and offered a way to send in specimens for testing.

While ADH is now using the more sensitive method of urine specimen testing to test for Chlamydia, this should not fully explain the observed increase in the rate among young women in Arkansas.

Narrative:
The Arkansas Department of Health continues to provide screening and treatment of sexually active females, their partners and males seen in local health unit STD, Family Planning and Maternity clinics. The Women's Health programs follow the American College of Obstetrics and Gynecologists and CDC guidelines for screening and treatment of clients requesting services in the family planning and maternity clinics. ADH has tested for Chlamydia and gonorrhea with DNA

amplification tests since mid-2007, which has resulted in an increased positivity rate reflected by the annual indicator increase to 46.5/1,000 in 2008. Evidence of leveling of the rate in 2009 supports the cause of the increase as being due to enhanced detection, although a true rise in incidence cannot be completely excluded. CDC's 2008 STD Surveillance reports Arkansas' Chlamydia positivity in Family Planning clients was 10.3%, STD patients 22.1%, and Prenatal patients 11.5%.

Participation in the CDC's Infertility Prevention Program provides funding to support testing of a portion of the ADH family planning clients through the ADH STD/HIV Section.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.6	7.4	9.3	12.6	12.5
Numerator	3596	3502	4385	5873	5856
Denominator	471518	471606	469950	467864	467864
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
2008 population estimate of female population 15-19 years used for 2009 indicator.

Notes - 2008
2007 population estimate of female population 20-44 years used for 2008 indicator.

Notes - 2007
2006 population estimate of female population 20-44 years used for 2007 indicator.

Like younger women, those over 20 are also showing remarkable increases in chamydia positivity. We are doing more urine testing, which may be more sensitive, but should not fully explain the observed increase in the rate among women in Arkansas.

Narrative:
Similar to the increase seen among adolescent females, the Chlamydia infection rate for 20-44 year old women continued to show an increase in positivity rate, now at 8.1% (compared to 7.8% of women 20 years and older in 2008) for women screened in the ADH local health units. This increase mirrors recent national trends. However, since ADH changed to a new DNA-based urinary screening method in 2007, much of the increase may be due to enhanced detection rather than a true rise.

Routine screening and treatment of asymptomatic, sexually active females has been shown to result in reduction in Chlamydia infection rates. ADH STD clinics routinely screen all clients 30 years old and younger and those over 30 with risk factors of: 2 or more sex partners in the last 12 months, a new sex partner within the last 3 months if diagnosed with an STD within the last year or anyone who is contact to a partner with gonorrhea, Chlamydia or non-gonococcal urethritis. Family Planning clinics screen all clients under 30 at their initial visit, all clients 25 and under

annually, and all clients over 25 if they have risk factors as cited above (STD clients over 30 year old). Maternity patients under ADH care receive Chlamydia screening at least once during pregnancy, with a repeat in late pregnancy if risk factors exist. All clinics screen those patients presenting with symptoms.

Continued adherence to national guidelines will be critical in controlling the spread of genital Chlamydia infections. However, expanded screening and treatment, as resources allow, must also be considered in light of the recently observed increase in frequency.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	41509	31259	9024	581	645	0	0	0
Children 1 through 4	160561	124309	31116	2270	2866	0	0	0
Children 5 through 9	191557	147810	38259	2571	2917	0	0	0
Children 10 through 14	189446	145295	39661	1929	2561	0	0	0
Children 15 through 19	197229	150253	42714	1990	2272	0	0	0
Children 20 through 24	186339	143353	38866	1952	2168	0	0	0
Children 0 through 24	966641	742279	199640	11293	13429	0	0	0

Notes - 2011

Narrative:
The relative proportions of racial groups has varied little in recent years. However, the rise in the Hispanic population has been rather dramatic (see HSI 06B). The northwest part of the state has a fairly large subpopulation of immigrants from the Marshall Islands, perhaps numbering up to 10,000 altogether. These people are included under the "Asian" category above as the US Census Bureau does not separate Pacific Islanders from Asians. The Marshallese have posed significant public health challenges due to cultural and language barriers and a relatively high prevalence of serious infectious diseases.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	36627	4882	0
Children 1 through 4	141357	19204	0
Children 5 through 9	172730	18827	0

Children 10 through 14	174721	14725	0
Children 15 through 19	185324	11905	0
Children 20 through 24	175179	11160	0
Children 0 through 24	885938	80703	0

Notes - 2011

Narrative:
The data above demonstating that Hispanic ethnicity is now seen among almost 12% of all Arkansas infants, but progressively less among older age groups (down to <6% of 20-24 year olds), reflects the continued rapid in-migration of younger Hispanic families who are having children within the state. Although once limited mainly to Northwest Arkansas, Hispanic communities are now thriving in every region of the state. Since most adult Hispanics are first-generation, there remains a strong need for Spanish-language health educational materials and cultural sensitivity in health care interactions.

Newly immigrated Hispanic children face a number of stressors, including those of acculturation, learning a new language, and living (often) in poverty conditions. A number of health disparities exist between Hispanics and non-Hispanic white children, with obesity (especially in males), asthma, teen pregnancy, dental caries, and behavioral and developmental problems all being more prevalent among Hispanic children and youth.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	76	37	35	1	0	0	0	3
Women 15 through 17	1612	943	570	7	1	6	0	85
Women 18 through 19	3886	2661	1038	15	1	12	0	159
Women 20 through 34	29588	22175	5263	114	98	356	0	1582
Women 35 or older	2867	2218	354	11	22	68	0	194
Women of all ages	38029	28034	7260	148	122	442	0	2023

Notes - 2011

Narrative:
Relative proportions of births to Whites and African Americans, by far the most common races in Arkansas, have changed very little over the years. What has changed is the proportion of births to those of Hispanic ethnicity (see HSI 07B).

Although Whites have more births overall to 15-19 year old teens than do African Americans, the proportion of births arising from this age group is higher for African Americans. About 12.9% of

all births to Whites are to 15-19 year olds, while this percentage for African Americans is about 22.1%. Among those of Asian descent, less than 2% of births occur to 15-19 year olds.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	70	5	1
Women 15 through 17	1411	191	10
Women 18 through 19	3550	317	19
Women 20 through 34	26379	3137	72
Women 35 or older	2436	420	11
Women of all ages	33846	4070	113

Notes - 2011

Narrative:
Hispanic women now account for 11% of births to women 20 years or older in Arkansas. This proportion has risen rapidly over the past decade in concert with a large influx of Hispanic people to the state. ADH has adapted to this demographic change by hiring Spanish-language interpreters for every health unit and producing (or purchasing) most health educational materials in both Spanish and English. However, cultural barriers still persist which sometimes impair the provision of health care services.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	270	153	79	0	4	1	4	29
Children 1 through 4	55	42	7	0	0	0	0	6
Children 5 through 9	27	17	9	0	0	0	0	1
Children 10 through 14	40	29	9	0	0	1	0	1
Children 15 through 19	127	85	33	0	0	1	0	8
Children 20 through 24	217	134	58	1	1	2	2	19
Children 0 through 24	736	460	195	1	5	5	6	64

Notes - 2011

Narrative:
As always, the first year of life exacts more fatalities than any other year in childhood. Compared to 2008, however, total numbers of infant deaths are down for both Whites and Blacks. Adolescence is also a dangerous period, but numbers of deaths for 15-19 year olds and 20-24 year olds are also down. These reductions are most striking for white 15-19 year olds. As postulated in the discussion for HSI 03C, new state laws related to (teenage) driving may already be manifesting beneficial results.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	231	21	18
Children 1 through 4	48	3	4
Children 5 through 9	25	1	1
Children 10 through 14	39	0	1
Children 15 through 19	117	4	6
Children 20 through 24	191	16	10
Children 0 through 24	651	45	40

Notes - 2011

Narrative:
The total number of deaths to Hispanic infants is up slightly compared to 2008, probably reflecting the rapidly rising births among this subpopulation in Arkansas. Non-Hispanic infant deaths are down, as are deaths to 15-19 year olds, both non-Hispanic and Hispanic. Reduced deaths due to injury almost certainly underlie this very encouraging observation.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	780302	598926	160774	9341	11261	0	0	0	2009
Percent in household headed by single parent	14.8	11.1	24.3	4.6	4.6	0.0	0.0	0.0	2009
Percent in TANF (Grant)	1.6	1.1	3.3	0.6	0.2	0.0	0.0	0.0	2009

families									
Number enrolled in Medicaid	414104	185940	88302	761	1228	0	0	137873	2009
Number enrolled in SCHIP	98202	61141	17222	190	505	0	0	19144	2009
Number living in foster home care	9299	4601	2105	42	21	0	0	2530	2009
Number enrolled in food stamp program	91304	52293	30124	379	285	418	495	7310	2009
Number enrolled in WIC	81248	56695	20379	541	575	545	2513	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009

Notes - 2011
Data source: US Census Bureau.

Data source: Arkansas Department of Human Services.

There were 246 native Hawaiian/Other Pacifiic Islander families, 524 families with more than one race reported and 8,739 other/unknown families in households headed by single parent . However, we did not have a population estimate for these race categories. Thus we could not determine the percent in household headed by single parent for in these race categories.

Data source: Arkansas Department of Human Services.

There were 9 native Hawaiian/Other Pacifiic Islander, 59 with more than one race reported and 259 other/unknown in TANF Grant families . However, we did not have a population estimate for these race categories. Thus we could not determine the percent in TANF Grant families for in these race categories.

Data source: Arkansas Department of Human Services.

Data source: Arkansas Department of Human Services.

Data source: Arkansas Department of Human Services.

Data source: WIC Program, Arkansas Department of Health.

These data were not available. The agency, Arkansas Crime Information Center, who is responsible for the data, was not able to break out juvenile crime arrests from total arrests by race and ethnicity. They are currently working on a new data software system that will make these data available in the the future.

These data were unavailable.

Data source: Arkansas Department of Human Services.

Narrative:
Differences between African Americans and Whites in relative utilization of services such as Medicaid, WIC, and food stamp programs are not surprising given persistent socio-economic disparities. Oher races are much smaller in number in Arkansas but tend to have relatively lower uptake of these programs.

Data on crimes committed by juveniles are not available by age group at present: however, the Arkansas Crime Information Center hopes to have age-specific data available within the next year. Data from the Arkansas Department of Education on high school drop-outs by race were requested but not yet received.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	710759	69543	0	2009
Percent in household headed by single parent	12.4	11.9	0.0	2009
Percent in TANF (Grant) families	1.6	0.3	0.0	2009
Number enrolled in Medicaid	388171	25933	0	2009
Number enrolled in SCHIP	90287	7915	0	2009
Number living in foster home care	9093	206	0	2009
Number enrolled in food stamp program	73069	6988	11247	2009
Number enrolled in WIC	68075	13173	0	2009
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	0.0	2009

Notes - 2011
Data source: US Census Bureau.

Data source: Arkansas Department of Human Services.

There were 18,915 families in households headed by single parent with ethnicity unknown. However, we did not have a population estimate for unknown ethnicity. Thus we could not determine the percent in household headed by single parent for those with ethnicity not reported.

Data source: Arkansas Department of Human Services.

There were 1,100 TANF Grant families in with ethnicity unknown. However, we did not have a population estimate for unknown ethnicity. Thus we could not determine the percent in TANF Grant families for those with ethnicity not reported.

Data source: Arkansas Department of Human Services.

Data source: Arkansas Department of Human Services.

Data source: Arkansas Department of Human Services.

Data source: WIC Program, Arkansas Department of Health.

These data were not available. The agency, Arkansas Crime Information Center, who is responsible for the data, was not able to break out juvenile crime arrests from total arrests by race and ethnicity. They are currently working on a new data software system that will make these data available in the the future.

These data were unavailable.

Data source: Arkansas Department of Human Services.

Narrative:
As stated elsewhere, a large proportion of Arkansas Hispanic families are relatively new to the U.S. Higher Medicaid enrollment rates among non-Hispanic than Hispanic youth may reflect reluctance to apply among Hispanic families due to the (incorrect) presumption that U.S. citizenship is required to qualify for benefits. Some Latino families may also fear that applying for Medicaid may be reportable to immigration authorities. Interestingly, however, a similar percentage of non-Hispanic and Hispanic children receive food stamp and WIC benefits. Within the stressful context of moving to a new country, obtaining employment and assimilating into the culture, procurement of health care coverage may simply be a lesser priority for some.

As with HSI #09A, data on juvenile crime arrests and high school drop-outs by ethnicity were not available this year.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	466649
Living in rural areas	313653
Living in frontier areas	0
Total - all children 0 through 19	780302

Notes - 2011

Narrative:
Although still considered a largely rural state, Arkansas has experienced the same trend of migration to urban areas seen in other parts of the country. The population estimates shown above reflect a continuation of this trend since last year's report. The northwest region of the state continues to grow rapidly, along with central Arkansas counties surrounding Little Rock. Slow but steady migration out of certain counties in southeast and southwest Arkansas also continues. As more and more people leave smaller towns, critical health service infrastructure is sometimes lost, making access to care all the more difficult for residents who remain.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2822138.0
Percent Below: 50% of poverty	5.8
100% of poverty	15.3
200% of poverty	40.2

Notes - 2011
2009 Total Population populated with 2008 population estimates.

Data source: 2008 Intercensal estimates, National Center for Health Statistics.

2009 poverty indicator is populated with 2008 data.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

2009 poverty indicator is populated with 2008 data.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

2009 poverty indicator is populated with 2008 data.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Narrative:
The percentage of Arkansans at less than all three of the above levels of poverty rose in 2009 as compared to 2008, probably as a result of the major economic downturn. With higher unemployment rates, more individuals qualify for services such as Medicaid (ARKids A and ARKids B), but concomitantly there is a diminished tax base to support the services. These factors help explain why Arkansas Medicaid is in the midst of a serious budgetary shortfall. Although no reduction in income eligibility criteria has been authorized, the planned raise to 250% FPL for pregnant women and for children's ARKids B benefits has been put on hold indefinitely. Such measures as additional pre-authorization of pharmaceuticals and exhaustive medical review prior to reimbursement for certain therapies are almost sure to materialize in an effort to contain costs.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	773598.0
Percent Below: 50% of poverty	9.7
100% of poverty	21.1
200% of poverty	51.4

Notes - 2011
2009 Total Population populated with 2008 population estimates.

Data source: 2008 Intercensal estimates, National Center for Health Statistics.

2009 poverty indicator is populated with 2008 data.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

2009 poverty indicator is populated with 2008 data.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

2009 poverty indicator is populated with 2008 data.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2009.

Narrative:
The proportion of children living at <50% FPL increased substantially in 2009 compared to 2008, when it was 6.3%. There was also a small rise in the percent living at <100% of poverty, while the fraction at <200% FPL stayed about the same. Arkansas has always been well above national measures for poverty prevalence at the <200% level. The noted increases in the <50% and <100% levels of poverty are no doubt related to the poor economy in the state and nation. The decline in state general revenue and the demand for more Medicaid services has led to a significant crisis in Medicaid funding.

Children are particularly vulnerable to the effects of poverty. Children often bear the brunt in terms of increased family dysfunction (abuse, neglect, discord, violence), worse environmental conditions, hunger, and emotional distress. Desperate families may turn to desperate measures to support income, including illegal activities. While it is difficult for Title V to directly effect an improvement in the economy, the program can help support high-risk children through services such as WIC, ConnectCare, immunizations, safety promotion, and efforts to reduce infant mortality.

F. Other Program Activities

The Title V Program provides the underpinning for virtually all maternal and child health efforts conducted through the Arkansas Department of Health. Examples of MCH-related activities not covered extensively elsewhere in this document include:

Health Literacy - Under the leadership of the former Director of the ADH Center for Health Advancement (Dr. Jennifer Dillaha), the Partnership for Health Literacy in Arkansas (PHLA) held an organizational meeting in July 2009. The meeting brought together organizations in Arkansas that are working in the area of health literacy to formulate steps to move the state forward. Members of the planning group include representation from the Arkansas Cooperative Extension Service, Arkansas Literacy Commission, Arkansas Children's Hospital, Arkansas Public Health Association and the Arkansas Department of Health, including the Women's Health Section. In May 2010, PHLA became an office section of the Arkansas Public Health Association (APHA) which will provide PHLA with an excellent (and affordable) venue for hosting an annual meeting

and providing training and continuing education in health literacy.

Training - The Center for Health Training and the ADH Women's Health Section sponsored the Women's Health Care Update 2010 on March 12th, 2010. National speakers presented information to over 200 participants on the following topics: Health Literacy, Reproductive Health Community Outreach, Reproductive Life Planning and Unplanned Pregnancy. A separate training on Client Centered Counseling was provided by Women's Health to the Northwest Region in April 2010.

Medical Supervision of Chronic Disease Programs - The Breast and Cervical Cancer Control Program (BreastCare) housed in the Chronic Disease Branch targets women over 40 who are uninsured or underinsured and who have rarely if ever been screened for breast or cervical cancer. The program offers free screening and follow-up to women who qualify. BreastCare has collaborated with a number of community organizations to provide outreach and education to vulnerable populations of women. The ADH Women's Health Physician Specialist, a board-certified OB/GYN, provides medical consultation to the program with regard to interpretation of screening results and referrals for additional testing. In addition to breast and cervical cancer, Title V staff at both the state and local level collaborate in other Chronic Disease initiatives such as diabetes prevention and control.

Community Health Promotion - Often utilizing Title V-supported ADH staff, Hometown Health Improvement Coalitions in all five regions carry out a variety of community activities that address issues including, but not limited to, teen pregnancy prevention, nutrition, physical activity and tobacco cessation. The primary target audiences are children in schools, worksites and aging Arkansans. Numerous activities throughout the state occur in various counties and include facilitation of health education presentations, dissemination of health education materials, organization of health awareness information booths, coordination of local health fairs, and implementation of special health-related and teen pregnancy prevention programs.

Evaluation - The Coordinated School Health (CSH) Program is undertaking a formal evaluation of its activities in collaboration with the Arkansas Center for Health Improvement. The multi-faceted evaluation will entail data collection from all CSH schools using an 80+ item survey tool, and will also incorporate outcome data on a number of measures including obesity, nutrition, physical activity, oral health, tobacco use, births to students, graduation rates and results of standardized achievement tests. Trends in CSH schools will be tracked over time, and comparisons to non-CSH schools will also be made. Preliminary data should be available by early 2011, with the full report expected in the spring of that year.

Enabling Services for Medicaid Beneficiaries - Also deserving of another mention is the work performed by the Health Connections Section within the Family Health Branch. Health Connections conducts the ConnectCare program under contract with Arkansas Medicaid. The program links both new and established Medicaid recipients with available primary care providers and dentists. Health Connections also provides outreach services to Medicaid beneficiaries using various modalities. Although most of the Section's funding is from Medicaid, Title V provides some direct financial support. Leaders in the Family Health Branch also provide direct administrative support and supervision for Health Connections Section personnel.

Toll Free MCH Line - The Arkansas toll-free MCH line (1-800-235-0002) is maintained under the auspices of the Health Connections Branch. Health Connections maintains detailed records on calls received including date, county of origin, and subject of the call. In SFY 2009, about 16,600 calls were received. The majority (about 13,500) pertained to the Happy Birthday Baby Book. The other 3,100 calls were on a variety of subjects such as how to access the closest WIC Office and where to go for other services such as family planning and immunizations.

G. Technical Assistance

Health literacy is defined in Healthy People 2010 as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." Health information as presented in the U.S. is often unnecessarily complex. A national survey of adult literacy found that 48% of the U.S. population has inadequate or marginal literacy skills. However, health literacy entails more than just the ability to read and write -- it also encompasses skills in numeracy, listening, and speaking, and relies on cultural and conceptual knowledge. Only about 12% of adults in the U.S. have "proficient" health literacy levels. Lower health literacy leads to less healthy behaviors, poorer health outcomes, and greater health costs.

Given even lower basic literacy rates in Arkansas, there is a great need to boost health literacy among the populace as quickly as possible. Initiatives are in place to promote health literacy among older Arkansans using the Stanford Chronic Disease Self-Management Program in a train-the-trainer model. Efforts to promote the medical home concept through Medicaid and other groups may also help boost health literacy. Still, further work is needed to promote health literacy among women and children seen through local health units as well as those touched through other ADH programs. Technical assistance on how to train ADH personnel in the most effective techniques of health information transmission would therefore be desirable. Such training is consistent with the strategies found under Goal 2 (Promote Changes in the Health Care Delivery System That Improve Health Information, Communication, Informed Decision-making, and Access to Health Services) in the recently released National Action Plan to Improve Health Literacy. Technical assistance might be requested from Health Literacy Missouri or possibly national groups.

The Title V CSHCN Needs Assessment identified the need for improved communication between families and CSHCN staff related to available programs and services. The new state performance measure will be measured based on the responses to an annual program survey. Assistance is needed in developing questions that will elicit information needed to indicate our progress on the measure. The information is not available from any data source owned by the program or available to the program, nor is it measured, to our knowledge, by other survey instruments such as the National Survey of CSHCN.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	7066705	6583838	7066705		7097785	
2. Unobligated Balance *(Line2, Form 2)*	597871	597871	627776		679554	
3. State Funds *(Line3, Form 2)*	3149026	7481595	4530304		7658325	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	0	95600	118969		147663	
6. Program Income *(Line6, Form 2)*	13052724	16950605	16037409		18734874	
7. Subtotal	23866326	31709509	28381163		34318201	
8. Other Federal Funds *(Line10, Form 2)*	5252013	4917629	4539857		4963156	
9. Total *(Line11, Form 2)*	29118339	36627138	32921020		39281357	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	3029303	3013833	2484696		2649786	
b. Infants < 1 year old	1342297	4029153	3361118		4663610	
c. Children 1 to 22 years old	4396430	5142517	4240023		5453294	
d. Children with	5664017	5230691	5872374		5730830	

Special Healthcare Needs						
e. Others	8836393	13511111	11259299		14355889	
f. Administration	597886	782204	1163653		1464792	
g. SUBTOTAL	23866326	31709509	28381163		34318201	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		93748		100000	
c. CISS	105697		105000		245000	
d. Abstinence Education	565101		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	100852		157461		530483	
j. Education	0		0		0	
k. Other						
HRSA	112365		198090		183052	
Title X	0		3985558		3904621	
Title X	4273354		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	14772736	19106684	16734136		20149556	
II. Enabling Services	4684096	5481983	6026875		6102013	
III. Population-Based Services	1853893	4787836	3279487		5412611	
IV. Infrastructure Building Services	2555601	2333006	2340665		2654021	
V. Federal-State Title V Block Grant Partnership Total	23866326	31709509	28381163		34318201	

A. Expenditures

Total Expenditures for the Total State MCH Budget FFY 2009 ($36,627,138) and the Federal-State MCH Partnerships ($31,709,509) was a substantial increase from FFY 2008. Expenditures at the Arkansas Department of Health and the Arkansas Department of Human Services increased due in part to higher salaries and increased supply costs. Total expenditures were greater than those budgeted, especially in Direct Care Services. The ADH's new time allocation system has captured significantly greater effort (salaries and fringe) in the MCH programs, which was paid with State general revenue. This is a more accurate estimate than we previously were able to obtain. In addition, we have included additional funds expensed on the Newborn Screening Program that represent expansion of that program and lab costs that were not included before.

The total state match contribution of $26,540,862 more than met the Maintenance of Effort

requirement of $5,797,136. The Arkansas Department of Health cost allocation system has significantly increased the amount of State contribution to the MCH Programs, because the amount of staff time spent on MCH Programs was higher than previously estimated.

Expenditures of program income of $16,950,605 were more than the $13,052,724 budgeted. Increased expenses for salary and fringe for clinic staff resulted in higher than projected costs. In addition the Expansion of our Newborn Screening Program contributed to expenses being higher than projected. This increase in cost was funded through the cost allocation system and increased fees for Newborn Screening.

Administrative costs increased as new support staff have been added. In addition the new cost allocation system recorded effort for MCH administration that had been missed previously.

B. Budget

Preventive and Primary Care for Children is budgeted at $4,258,671 or 60 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,224,446, which is 31.34 percent of the total. The Title V administrative costs are estimated at $614,668, or 8.66 percent of the total allocation. The amount of total State funds budgeted is $7,658,325, which is a significant increase from the amount budgeted previously. This reflects state dollars directly budgeted in the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services' MCH programs and to the state effort through salaries paid from state general revenue that support MCH programs captured in time allocation reports. Time allocation is more accurate than it had been in the previous application due to a new time allocation system at ADH. The total state match is $26,540,862. Each of these budgeted items satisfies the legislative requirements.

The state funds spent in CSHCN total $1,927,852. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. Without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. CSHCN program income for FFY 2009 fell below projections due to reduced reimbursements.

Policy Development, Program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Block Grant. The Title V Block Grand funds provide an essential link between the programs in our state serving children and mothers. The funds provide a bridge between the Arkansas Department of Health and the Arkansas Department of Human Services, that creates a partnership resulting in better coordination and efficiency in serving the citizens of the state. It also serves as a platform from which new initiatives and partnerships outside of state government, such as the Natural Wonders Partnership, are made to tackle the health issues of the State's children and women.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.